RIVERSIDE ELEMENTARY SCHOOL DISTRICT NO. 2

Riverside Elementary School District No. 2 pays 100% of the premiums for medical (Value Silver Plan), dental, vision and basic life insurance coverage for the employee only.

Please read through the attached packet and review coverage options available to you. Human Resources would be glad to answer any questions you may have.

Group Insurance Premiums

RIVERSIDE SCHOOL DISTRICT NO. 2

MEDICAL - ASBAIT /MERITAIN

		Rate	RESD Contribution	Employee Monthly Contribution	Employee Per Pay Period Rate (22)	Employee Per Pay Period Rate (26)
Value Silver	Employee Only	$770.00	$770.00	$0.00	$0.00	$0.00
	Employee + Spouse	$1,541.00	$770.00	$771.00	$421.00	$356.00
	Employee + Child(ren)	$1,387.00	$770.00	$617.00	$337.00	$285.00
	Employee + Family	$2,233.00	$770.00	$1,463.00	$798.00	$676.00
Classic Silver	Employee Only	$860.00	$770.00	$90.00	$50.00	$42.00
	Employee + Spouse	$1,718.00	$770.00	$948.00	$518.00	$438.00
	Employee + Child(ren)	$1,547.00	$770.00	$777.00	$424.00	$359.00
	Employee + Family	$2,493.00	$770.00	$1,723.00	$940.00	$796.00

IMS Mexico Network = $3.28 per paycheck (22 pays only)

DENTAL - DELTA DENTAL

	Rate	RESD Contribution	Employee Monthly Contribution	Employee Per Pay Period Rate (22)	Employee Per Pay Period Rate (26)
Employee Only	$37.78	$37.78	$0.00	$0.00	$0.00
Employee + Spouse	$78.91	$37.78	$41.13	$23.00	$19.00
Employee + Child(ren)	$93.48	$37.78	$55.70	$31.00	$26.00
Employee + Family	$153.07	$37.78	$115.29	$63.00	$54.00

VISION - DELTA VISION

	Rate	RESD Contribution	Employee Monthly Contribution	Employee Per Pay Period Rate (22)	Employee Per Pay Period Rate (26)
Employee Only	$6.06	$6.06	$0.00	$0.00	$0.00
Employee + Spouse	$12.13	$6.06	$6.07	$3.31	$2.81
Employee + Child(ren)	$11.83	$6.06	$5.77	$3.15	$2.67
Employee + Family	$18.50	$6.06	$12.44	$6.79	$5.75

LIFE - PRUDENTIAL

$40,000 basic life insurance policy paid by RESD

Optional Life Insurance for Employee & Dependents
Premiums are based on annual salary & age

Employee Only
($100,000 - $500,000)

Spouse
(cannot exceed 50% of employee amount; $5,000 - $100,000)

Children
(cannot exceed 50% of employee amount; $5,000 - $10,000)

Short Term Disability
60% of weekly earnings up to $1,000
Premium is based on annual salary & age

PET - UNITED PET CARE

	Employee Per Pay Period Rate (22)
1 Pet	$9.56
2 Pets	$18.55
3 Pets	$27.55
Each Additional Pet	$9.00

i.e. 4 pets = $36.55

2023-2024 SY

Medical

INSURANCE

A Guide to Your Benefits and Enrollment

2023–2024

Banner|Aetna Network Handbook
Transforming Health—Improving Lives

Follow us: www.asbait.org | ASBAIT | @asbaithealth

Trust the people who care for you

About ASBAIT

The Arizona School Boards Association Insurance Trust or ASBAIT was established in 1981 by the Arizona School Boards Association. Its formation was in response to Arizona school administrators desire to obtain comprehensive health benefits at reasonable costs. Meeting the needs of employees and their dependents is at the core of ASBAIT's philosophy. These factors differentiate ASBAIT plans from commercial employee benefit programs making it the number one choice with Arizona schools.

Mission statement

The mission of the Arizona School Boards Association Insurance Trust (ASBAIT) is to set the standard for service, benefits and affordability for the health care of Arizona's school employees and their dependents.

Governance

ASBAIT was set up and operates by an "Agreement and Declaration of Trust" in accordance with the laws of the State of Arizona, including, without limitation, Arizona Revised Statutes Section 15-382 as it may be amended from time to time.

Operational authority of the Trust is by the Board of Trustees. The ASBAIT Board of Trustees is comprised of governing board members, superintendents, and business managers from member districts from across the state. As Trustees end their term of service and seats become available, the ASBA executive director will select, interview and make Trustee recommendations to the Arizona School Boards Association's (ASBA) board for appointment.

The Trustees meet four to six times per year to conduct the business of the Trust. Their major responsibilities include approving renewal procedures, overall budget, contractors, and independent audit and actuarial reports. The Trustees may also hear and make decisions on Appeals or Exceptions for claim payments to member employees or dependents.

"We believe the school employees who work each and every day educating, nurturing, guiding and protecting students must be supported to perform to their highest ability, and we believe that begins with their health."

Barbara Underwood, ASBAIT Chairperson

Bring healthy balance back to your life

Finding your perfect balance

ASBAIT knows how important it is that you understand how your benefits work.

That's why this packet contains:

- Useful information about your benefits plan.
- Everything you need to choose the best options for you and your family.
- Instructions on how to enroll, and to begin using your new benefits.

Why do we feel this is important? Because, let's face it, living today can be larger than life. Getting through the day at top speed is a sign of our hurry-up, drive-through times. Many people put themselves at the bottom of their to-do lists, giving everything else the best of their energy.

In this way, life gets out of balance. Most of us can keep juggling it all until one day health and well-being begin to pay the price.

Take a deep breath, step back and see the big picture. Help yourself. Put that life on pause for a few minutes, and take the time to read this packet. You'll see that ASBAIT and your employer provides tools, resources and benefits to help you regain your best life and make smart health care decisions.

We want to help you get the most from your benefits—so you can live a life that's balanced and informed.

A balanced life means a healthier you.

These materials were created to help you understand the benefits available to you. This is not a Summary Plan Description (SPD) and is not intended to replace the benefit summary or Schedule of Benefits (SOB) contained within the plan. If any provision of these materials is inconsistent with the language of the plan, the language of the plan will govern. Meritain Health is not an insurer or guarantor of benefits under the plan.

Who is Meritain Health?

Meritain Health is your health care benefits administrator. We process your health care claims and provide customer service for ASBAIT. This is why you will see our logo on your ID cards and benefit documents.

Meritain Health provides easy-to-use health care benefits you can use to live well. We also take steps to help you save on the cost of your care. Contact us at the number on your ID card if you have any questions about your plan.

What's inside?

In this packet, you'll learn more about the following:

Preventive care

- Annual exams and check-ups
- Well-child care
- Immunizations and screenings

Health care benefits when you need them

- Inpatient and outpatient care
- Home health care
- Teladoc Health™
- Rehabilitation services
- Doctor visits and prescription drugs
- Mail order and online prescription options
- A large and convenient provider network
- Important programs to help you live a happier healthier life

Support when you need it

- **ASBAIT Nurse Health Coaching—**you'll get the help you need to manage costs related to your condition, including the highest cost of all—the impact of your condition on your quality of life. You can earn up to a $100 incentive annually for each member who participates.
- **Banner Nurse Now—**just call **1.602.747.7990** or **1.888.747.7990** to get connected.
- **Employee Assistance Program (EAP)—** counseling when you need it, 24/7. Your EAP is brought to you by Alliance Work Partners.
- **Maternity management—**for a healthy pregnancy and child birth, you need pre-term and post-partum care, tailored to your health needs. You can earn up to a $100 incentive annually for each eligible member who participates.
- **Case management—**a no-cost program that helps you and your family navigate your health benefits when unexpected illness or injury occurs in your life.

ASBAIT dental and vision benefits (if offered by your district)

For a listing of your dental and vision benefits, please refer to your Summary of Benefits (SOB). Refer to your Summary Plan Document (SPD) for more complete information.

Programs for healthy change

- **Working~Well Employee Wellness Program**—support for improving and maintaining your own good health with a holistic approach.
- **Biometric testing**—watch for an announcement at your school. We come to you and complete a confidential 37 panel blood profile. You then receive your personal results with informative detail to raise your health awareness. It is our gift to you in early detection and prevention.
- **Hinge Health**—ASBAIT members also have access to this innovative service which provides sensor-guided exercise therapy virtually for chronic back or knee pain, as well as one on one coaching. You are able to access therapy wherever you are, on your own schedule.
- **Mobile On-site Mammography**—watch for an announcement at your school. Mammography services are conveniently provided for eligible members at the workplace.
- **SkinIO™ Program**—You have access to easy, intuitive self-screening technology for skin cancer. From the comfort of home, you can take secure photos of your skin using your smartphone. Photos are securely routed to a board-certified dermatologist for review. If needed, you will receive an outreach call to help connect you with care and answer any questions.

No surprises, just information

In this section

- What's new for 2023-2024
- Health benefits for your family
- Enrolling at a later date
- Special enrollment situations
- If your spouse already has coverage
- Effective, July 1, 2023 every ASBAIT medical member will have access to Teladoc Health!

What's new for ASBAIT members in 2023

1. There are no changes to the plan designs for the 2023-2024 plan year.
2. We are excited to announce an enhancement to the ASBAIT medical plans. Effective July 1, 2023 all ASBAIT medical members and their dependents will have access to Teladoc Health.
3. All ASBAIT medical members now have access to the PrudentRx Program to help members save on specialty medications.

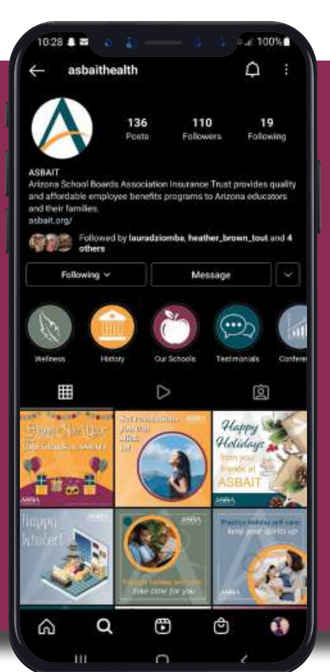
Follow ASBAIT on social media!

We want to keep you informed about your benefits program. As we're continually trying to increase the ways we communicate with you, we've added a YouTube page and Instagram. Search for ASBAIT on YouTube for informational videos and messages about your benefits. Follow us on Instagram (@asbaithealth) for regular posts to learn more.

QR Codes:

ASBAIT.org Instagram

YouTube



How health care reform affects your plan

In March 2010, President Obama signed the Affordable Care Act, or ACA, into law. The ACA, also known as health care reform, includes certain consumer protections that apply to your health plan, for example, the requirement for the provision of preventive health services without any cost sharing. Be sure to review the important information about the ACA that is included throughout this kit.

Important things to know about eligibility

Health plans are put together carefully to provide the best benefits possible for participants. ASBAIT and Meritain Health know how important it is for health care consumers like you to really understand how your plan works. In this way, you can make the changes you want in your health and in your life. The next section of this packet describes some of the most important provisions of your benefits. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed, with no surprises.

Special enrollment situations

In some situations during the year or after open enrollment, you may be able to add, delete or change your benefit choices.

- Involuntary loss of other benefits.
- Change in marital status.
- Death of covered spouse or dependent.
- Birth.
- Adoption.
- Placement of a child in your home for adoption.

Refer to the Summary Plan Description (SPD) for a full description of special enrollment.

Healthy balance for your family, too

Your family members can also reap the rewards of the plan. Health care benefits are available for every eligible dependent. It's a great way to help your family members find the right balance between life's "roller-coaster ride" and their best health. Be sure your family knows about the opportunities open to them—share this packet and other materials you receive from the plan!

Your eligible dependents

This benefit plan is open to you and your eligible dependents. An eligible dependent is:

- Your spouse (as defined in your plan documents).
- Your children, natural or adopted.
- Stepchildren.
- A domestic partner that is living in your home (could vary by district).
- Children who have been placed with you for adoption.
- Children for whom you are the legal guardian.

ACA note: Dependent coverage is available for any child (regardless of marital status, residency, student status, etc.) of an employee who is deemed to be the employee's biological, step, foster or adopted child (including a child placed for adoption) until the end of the month in which such child reaches age 26.

Family members covered by a different plan

If a family member is covered by a different plan:

- You can enroll yourself and your eligible dependents in this plan.
- You can enroll yourself in this plan, but decline benefits for some or all dependent(s).
- You can decline benefits for your whole family.

Are your dependents still eligible for benefits under your plan?

Tell your employer if:

- You become divorced or are legally separated from a spouse who was covered under this plan.
- A dependent child ceases to meet the eligibility terms of the plan.

To enroll the dependent for COBRA—a special limited-time plan for continuing benefits at your own expense—you must notify your employer within 60 days of that person's change in dependent status.

When you have benefits from two group plans

If you or one of your dependents have benefits under both this plan and another plan, the two plans will coordinate your benefits. One plan will be considered the primary plan (or first payer) and the other will be the secondary plan (pays only after the first plan has paid).

Generally, Meritain Health uses a birthday rule to decide which plan would be the primary plan.

Please refer to your SPD for specific requirements.

If you say "no" to this plan now

You can refuse the benefits of this plan, but be sure you've looked at the pluses and minuses of that decision.

Important: If you don't enroll now, you'll have to wait for your employer to offer an open enrollment period or until you're eligible for a special enrollment due to a qualifying event.

Open enrollment period

You and your eligible dependents may enroll for coverage during this time called Open Enrollment. Your school will communicate your dates of open enrollment.

Your member website

Meritain Health provides ASBAIT members with a secure member website at **www.meritain.com**. It is designed to provide a secure, user and family-friendly, one-stop-shop for you to access the account and claims information.

Your online tools and resources

With a www.meritain.com account you can:

- Find the status of a claim /view EOBs.
- Find in-network doctors, clinics and hospitals.
- Look up prescription and over-the-counter drug information.
- Download and order ID cards.
- And more.

Your secure member site

Visit **www.meritain.com**.

Return users, just sign in using your username and password. The first time you access the site, you will be prompted to re-register with a new username and password for enhanced security. Then take advantage of the smart, safe resources your health plan offers, right at your fingertips.

New users can create an account by following the easy instructions. You'll need your health plan ID card the first time. Remember, each member of your family can have an account, too.

If you need help registering, you can contact Meritain Health Customer Service at **1.866.300.8449** or **1.602.789.1170**.

How to access your mobile progressive web app

For iPhone®:

- Once you log in to your member website through **www.meritain.com**, click the icon at the bottom of the page.
- Then, scroll through the menu options and select *Add to Home Screen*.
- Click *Add* in the upper right-hand corner.
- Your Meritain Health app logo will then be installed and added to your home screen.
- Then, you'll be able to log in through the app, instead of going though the web page.

For Android™:

- Once you log in to your member website through **www.meritain.com**, you'll be prompted with the pop-up message *Add Meritain Health to Home Screen* at the bottom of the page. Click this message.
- Then, you can click *Add* to add the logo to the home page or *Cancel* to opt-out.
- Your Meritain Health app logo will then be installed and added to your home screen.
- Then, launch the app from your home screen and log in.

Privacy regulations

Members over 18 years of age have partially protected information according to HIPAA Privacy Regulations.

Members over 18 having difficulty creating an account with their Social Security number (SSN), please contact Meritain Health Customer Service at **1.866.300.8449** or **1.602.789.1170**.

Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their Protected Health Information (PHI) for treatment, payment or health care operations; and (ii) the health plan's disclosure of their PHI to persons who may be involved in their health care or payment thereof (e.g., family members, close friends).

Balancing your life means protecting your health

In this section

- Preventive care
- Using your provider network
- Teladoc Health: Access to care, 24/7
- ASBAIT's Nurse Health Coaching
- Medical Management and precertification
- Employee Assistance Program (EAP)
- Hinge Health: digital therapy app
- SkinIO: skin screening program
- On-site biometric screenings
- Prescription benefits

Understanding your medical benefits

Chances are, you try every day to restore a healthy balance to your life, but time gets away from you, or other details come first. ASBAIT and Meritain Health are here to help you focus, to support you every step of the way. Read about your benefits in the next sections, and learn all you can about using your plan to make healthy changes. Think of the benefits and programs as an important resource in the protection of your body, mind and spirit!

Preventive care for you and your family—protecting your healthy balance

Question: Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?

Answer: Nothing makes more sense in these busy times than preventing illness before it happens. That's why your ASBAIT medical plan offers excellent benefits for preventive services.

Take an easy step towards good health

The number one way to help yourself and your family stay healthy is with preventive care. When combined with healthy eating and exercise, vaccines and early detection are your key to a long and healthy life. That's why ASBAIT and your employer offer many preventive treatments at no cost to you when you visit a doctor in your network.

Using your medical benefits

Save when you see network providers

The ASBAIT plan offers a provider network of doctors and other health care professionals who have agreed to accept lower amounts than their standard charges, just for members of the ASBAIT plan. These lower amounts are negotiated and predetermined. That means when you see a network provider, your share of costs is based on a lower charge—so your costs are lower, too.

Network providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that ASBAIT can support your efforts to stay well and have a healthy lifestyle—or to have simple access to care.

No referrals required

You don't have to choose a primary care doctor to direct all of your care or to provide referrals to specialists, but we recommend you build a relationship with an in-network primary care doctor who will help to coordinate your care with all members of your care team. For the best benefits, see providers that are in the network (called in-network or participating providers). Remember, if you see providers outside the network, you'll share more of the cost. To be sure the plan pays for charges from any out-of-network provider you choose, call customer service before you receive care.

Your Banner|Aetna Network

Maricopa, Pima, Coconino and Pinal County schools are eligible for this exclusive, patient-focused health care program. Banner|Aetna is working to reinvent the health care system in Arizona to deliver:

- More convenient visits for you that result in shorter wait times.
- A care model that empowers providers in your community.
- Greater efficiency and affordability with each visit.

The Banner|Aetna program allows you to build a deeper relationship with providers in the Banner Health Network system by putting the focus on you, the patient. You will experience medical care that is proactive, not reactive. This puts the focus on wellness and managed chronic conditions before more serious issues can develop.

ASBAIT Network: Banner|Aetna and Aetna Choice® Point of Service (POS) II networks

When you need medical services, you have access to providers in the Banner|Aetna network within Arizona, and the Aetna Choice POS II network nationally including Arizona. This is a broad national network that's provided with all ASBAIT health plans including over 277,079 primary care doctors, 497,710 specialists, 847,470 non-physician specialists and 6,248 hospitals. It's easy to find doctors and hospitals in your network. You can find network providers online or by phone.

About the Banner|Aetna network

You have access to an exclusive, patient-focused health care program right in your community!

- Banner|Aetna providers are available near you, and include a medical director, doctors, specialists and a full support staff.
- Providers use a shared database to ensure they're all accessing the same patient health history. This system ensures coordinated care and improved provider engagement throughout each member's health care journey.
- You'll get the support of an on-call nurse for help scheduling appointments, finding network providers, and answers to your health questions.
- We strongly encourage you to select a primary care physician to help coordinate your care with all members of your care team.

Why visit a provider in the Banner|Aetna network?

You pay lower out of pocket costs plus gain the advantage of connected providers offering more efficient care for the best possible health outcomes.

Your Banner|Aetna medical plan has three network benefit tiers for you to choose from:	
Tier 1	**Banner in-network (lowest cost share option)** Banner|Aetna is focused on driving the quality of care through greater efficiency and affordability.
Tier 2	**Aetna Choice Point of Service II (POS II)** A broad national network that's provided with all ASBAIT health plans.
Tier 3	**Out-of-network coverage (highest cost share option)**

When it's an emergency

If you can't see a network provider in an emergency, don't worry! Your plan will cover out-of-network emergency charges at the in-network level. For more information, refer to your SPD.

When out-of-network charges may be covered at the in-network rate

If an out-of-network provider is under agreement with an in-network provider for some part of your care (for example, an out-of-network anesthesiologist or pathologist who regularly works with your doctor) the out-of-network provider's charges will be paid at the in-network rate subject to usual and customary charges. All plan limitations, requirements and provisions apply.

Important: if you (or your in-network provider) could choose an in-network provider for services or consultation, but decide instead to use an out-of-network provider, benefits are reduced to the out-of-network level.

Helpful tip

If you go outside your provider network, you may still have benefits, but your share of costs will be much higher, and the amount you pay will not be based on a lower negotiated rate.

Find Banner|Aetna providers online

You can use the DocFind directory anywhere you have Internet access. Just:

1. Visit: **http://www.aetna.com/docfind/custom/mymeritain/**.
2. Key in your location (ZIP code, city, county or state). Then, choose range (e.g., within 25 miles).
3. Under *ACO/Joint Ventures*, choose ***Banner Choice POS II*** (below *Select a Plan*).
4. Next, type the provider name or type of provider, or select from the categories listed. The guided flow search will use some of our most commonly searched terms and easily organize them for you to find. Your provider results will continue to be returned based on relevancy to your search criteria (plan, location and search term).
5. You have three tiers of benefits: Tier 1 Banner providers, Tier 2 Aetna Choice POS II providers, and out-of-network.
6. Banner providers (Tier 1) are identified in search results as: **Banner Health Network, Maximum Savings—the provider provides maximum savings for you**.
7. Aetna Choice POS II providers (Tier 2) are identified in search results as: **Standard Savings—the provider is in network. To save more, look for a maximum savings provider**.

If your school offers dental benefits with Aetna Dental Administrators, you can also use DocFind to search for dental providers:

1. Visit: **www.aetna.com/docfind/custom/mymeritain/**.
2. Choose: *Aetna Dental® Administrators*
3. Choose *Aetna Dental Access®/Vital Savings by Aetna®* under *Select a Plan*.
4. Choose your provider from the list of providers displayed on the results screen. Learn more about each by clicking on the provider's name.
5. Narrow your search results by using the filters under *Narrow Your Results*. Choices include *Group Affiliations*, *Languages, Gender* and *Specialty*.

For more search tips, you can click on *Search Tips and FAQs* on the home screen.

If you have questions while searching for a doctor or hospital, simply click on the *Contact DocFind* link. It's at the top of any DocFind page. You'll be able to send a quick comment or question.

If you need more information about Banner|Aetna providers, just call the Banner Nurse Now Service at: **1.602.747.7990** or **1.888.747.7990**.

Find providers by phone

Need a provider when you're not near a computer? No problem. Simply call the Aetna Provider Line at **1.800.343.3140** from 8:00 AM–9:00 PM ET, Monday through Friday.

Banner Health Banner Nurse Now

You have access to the Banner Nurse Now. Just call **1.602.747.7990** or **1.888.747.7990** to get connected.

When you call the Banner Nurse Now line, you'll access:

- Free health care advice that supports services you receive from your primary care doctor.
- Help getting the right kind of care. Banner Health Network nurses will advise you on at-home care, or whether you should visit an urgent care clinic or the emergency room. Plus, they'll help you find a nearby facility.
- Connection to other Banner Health services. These include:
  - A Banner Health pharmacist
  - The Banner Poison and Drug Information Center
  - Banner Behavioral Health
  - The Banner Information and Referral Line
  - Many other Banner Health resources online or by phone.

Teladoc Health—No Additional Cost

Members receive access to care 24 hours, seven days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits.

Teladoc Health is the on-demand health care solution that gives you the medical care you need, when you need it. Talk to a doctor anytime, anywhere about non-emergent medical conditions such as:

- Allergies
- Bronchitis
- Cold/flu
- Headaches/migraines
- Eye/ear infections
- Rash/skin infections
- Sinus infections
- Stomach/diarrhea
- Urinary tract infections

Use Teladoc Health for medical advice and care when:

- Your primary care doctor is not available.
- You are at home, traveling or do not want to take time off work to see a doctor.

Your Teladoc Health benefits:

- $0 copay if you are covered on a non HDHP plan.
- $49 copay if you are covered on an HDHP plan.
- All dependents in the household are covered even if they are not enrolled on the medical plan.
- Starting July 1, 2023 ASBAIT medical members** can register themselves and their dependents (even if the dependents are not covered on an ASBAIT medical plan) under the ASBAIT Teladoc Health benefit. You must be registered in order to utilize the benefit*.

How to Access Teladoc Health:

Set up your account by phone (toll-free), web and mobile app.

- **Online.** Go to **Teladoc.com** and click Set up account.
- **Mobile app.** Download the app and click *Activate account*. Visit ***teladoc.com/mobile*** *app* to download the app.
- **Call Teladoc Health at 1.800.Teladoc.** Teladoc Health can help you register your account over the phone.

Once you are registered, you can request a consult anytime you need care. And talk to a doctor by phone, web or mobile app. Your Teladoc Health consult is just $49 if you have an HDHP, or $0 for a non-HDHP.

**If you have already registered under your current employer for ASBAIT's Teladoc Health benefit, you will not need to re-register. If you previously received care under another employer or line of coverage, you will need to re-register in order to receive the benefits as described above.*

***If you waive ASBAIT medical coverage, please check with your district to determine if they extend Teladoc Health benefits to those not enrolled on an ASBAIT medical plan.*

ASBAIT's Nurse Health Coaching

If you have an ongoing medical condition, you are far from alone. According to a recent study, nearly 50 percent of Americans have medical conditions of one kind or another. These conditions cause major limitations in daily living for almost 1 out of 10. However, by adopting healthy behaviors, such as eating nutritious foods, being physically active and avoiding tobacco use, you can reduce or eliminate complications associated with your condition.

Controlling your condition

The goal of the Nurse Health Coaching Program is to help you control your chronic condition, rather than allowing the condition to control you. At the same time, the program will help you set achievable steps and goals to assist you with living a healthy lifestyle.

ASBAIT's Nurse Health Coaching Program helps members manage the following conditions:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic pain (caused by arthritis or lower backpain)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- Hyperlipidemia
- Hypertension

Participating in the program

If you are invited to participate and you choose to do so, you will promptly receive information about the program's resources and educational opportunities.

If you feel you would benefit from the ASBAIT Nurse Health Coaching Program and have not been contacted, you have the option to self-enroll. To learn more about the program or to enroll today and start speaking to a nurse health coach, call **1.855.5ASBAIT** or **1.855.527.2248**.

Maternity Management: a balanced beginning for you and your baby

Through this program, you will be assigned your own maternity nurse specialist. Your nurse will get you answers to questions and concerns and will help you follow your doctor's plan for your care.

Specifically, your Maternity Management nurse coach will:

- Help you set targets and goals, such as lowering your blood sugar, controlling your blood pressure and reducing your cholesterol.
- Provide information on warning signs and symptoms and what to do if they occur.
- Help you comply with your physician's plan of care.
- Provide educational resources specific to your needs.
- Direct you to local community resources.

Think you may benefit from the program? If you think you would benefit from the program and want to enroll, but you have not been contacted, please call **1.855.527.2248.**

Medical Management

ASBAIT and your employer want you to get the best, most appropriate care, when and where you need it. That's why your plan includes the extra expertise of ASBAIT's Medical Management program. The Medical Management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Incentive Program

You can recieve $100 per member for your participation in the Nurse Health Coaching or Maternity Management programs. This incentive is paid directly to qualifying members ($25 per quarter).

Want to join? Call **1.855.5ASBAIT** or **1.855.527.2248**

How to obtain precertification

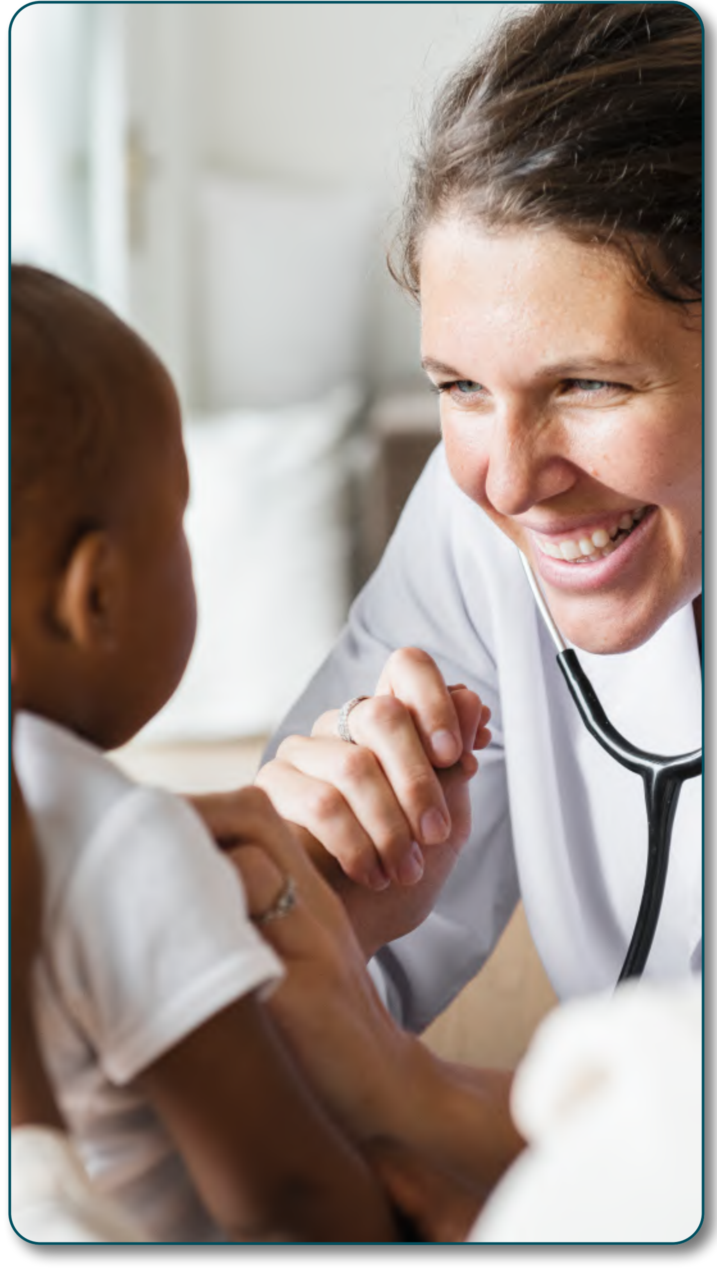
For non-emergency procedures and hospital admissions: The covered person or the physician must contact Medical Management prior to the admission or in advance of the procedure. Often times this is done by your physician, but it is the member's responsibility to make sure that all required precertifications are completed. Medical Management will review the request for services and contact the physician for any records or additional information necessary to thoroughly evaluate the need for services.

For emergency procedures or hospital admissions:

The covered person, the physician, the hospital admissions clerk or anyone associated with the covered person's treatment, must notify Medical Management by telephone within 48 hours of the procedure or admission.

Precertification of a procedure does not guarantee benefits

All benefit payments are determined by Meritain Health, in accordance with the provisions of this plan. The program is designed as a cost-containment program to maximize the plan benefits and reduce unnecessary hospitalizations, surgical procedures and other diagnostic services. Once a precertification has been received, it is valid for a period of 90 days.



Before you get care, check precertification (Medical Management) requirements

The following items and/or services must be precertified before any medical services are provided:

- All inpatient facility admissions
- Outpatient and physician surgery
- Outpatient and physician diagnostic services
- Non-orthopedic CT and MRI
- PET scan, sleep study
- Chemotherapy (including oral)
- Radiation therapy
- Oncology and transplant-related injections, infusions and treatments
- Dialysis
- Hyperbaric oxygen
- Home health care
- Durable medical equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices
- High-cost drugs: injectables that cost $2,000 or more per drug, per month
- Infusion therapies that cost $2,000 or more per drug, per month

For an all-inclusive list, please refer to your plan document.

Failure to comply with the precertification requirements may result in penalties which you will be responsible for. A 20 percent reduction in benefits may be taken, or you may be disqualified from benefits altogether. Your doctor may request precertification for you, however you are ultimately responsible for making sure precertification is obtained when required.

ASBAIT Medical Management

You can contact a medical management nurse by calling **1.855.5ASBAIT** or **1.855.527.2248**.

Your ASBAIT Employee Assistance Program (EAP)

ASBAIT offers an EAP because we know life can be stressful. Alliance Work Partners (AWP) provides confidential services at no cost to you and your household. Designed to help you with responsibilities, events, work stress and issues affecting your quality of life, AWP is available 24 hours a day, seven days a week.

Your ASBAIT EAP Program:

- Is confidential and available at no cost
- Is available to all employees, their household, dependents (age 26 or under), terminated employees (for six months), and retirees.
- Gives you and your family access to up to five short-term counseling sessions per problem per year, which includes assessment, referral and crisis services.

Additional programs included with your EAP program:

- **LawAccess:** legal and financial services.
- **WorkLife:** community services and referrals.
- **SafeRide:** reimbursement for unanticipated cab and ride-share services.
- **HelpNet resources:** access to webinars, legal forms, training and financial tools.

Visit your EAP website and create a customized account by following the below steps:

- Go to **www.awpnow.com**.
- Choose *Access Your Benefits* to create an account or log in.
- Registration code: **AWP-ASBAIT-2811**.

For further information or assistance regarding this beneficial program, contact Alliance Work Partners:

- Toll free: **1.800.343.3822**
- TDD: **1.800.448.1823**
- **Teen Line: 1.800.334.TEEN (8936)**
- Email: **AM@alliancewp.com**

HINGE Health

This is an additional benefit included with your ASBAIT medical plan that offers **FREE** physical therapy when you need it.

HINGE Health is a digital tool that delivers a customized care plan for all members and a sensor-guided exercise therapy program for chronic pain, along with access to interactive one-on-one coaching.

To learn more, visit:

- Website: **hingehealth.com/asbait**
- Email: **hello@hingehealth.com**
- Call: **1.855.902.2777**

(Hours of operation: Monday-Friday, 9:00 AM-9:00 PM)

SkinIO early detection

SkinIO is the easiest way to get your annual skin screening, and it is completely **FREE** with ASBAIT.

Your skin will tell you it has a problem long before it becomes a serious problem. With the SkinIO virtual program, all you need to take control of your skin health is your smart phone and 15 minutes. Your skin screening will be securely sent to a board-certified dermatologist, who will review your skin for any concerning spots.

Skin cancer impacts one in five Americans. Caught early, it's a manageable fix. With SkinIO, your skin health is now in your hands and you will be able to track changes year over year!

How SkinIO Works

You will be guided to take clinical-grade photos of your skin. The technology helps you through documenting and tracking changes to your skin over time.

For additional information on this program, please contact SkinIO via email at **help@skinio.com** or toll-free at **1.855.754.6400**.

On-site biometric screenings

Biometry is a measure of your body's performance and health. If your employer agrees to participate (and meets required minimums), we come to you—at your work place—to help you get a picture of your current health. The program is voluntary and confidential. If on-site screenings are not available to you, there is also an option to test at a lab.

Here's how it works

Professionals will conduct a health risk assessment—a confidential survey about your personal health and history—right at your work place. In a private setting, they'll take your blood pressure and draw a blood sample for a blood chemistry profile. This will be used to determine your health today.

Once you've completed the blood draw, you'll be able to view a personalized, confidential report showing your results. The report will include any "heads-up" messages about areas you might need to discuss with your doctor.

ASBAIT prescription benefits: your prescription drug benefit is managed by CVS Caremark®

Your prescription drug benefit is available when you need prescriptions filled. You can visit more than 68,000 retail pharmacies nationwide to fill your prescriptions. You also have access to clinical pharmacists for information and support.

Prescription drug tiers	
Tier 1	Lowest cost drugs, mostly generic
Tier 2	Medium-cost drugs, most are generic; some are brand-name
Tier 3	Higher cost drugs, most are brand-name; some specialty
Tier 4	Highest cost drugs, most are specialty

Non-HDHP Plan Prescription Benefits

Service	Retail	90-day supplies
Mandatory generic	$15	$30
Preferred brand-name* (when no generic is available)	20% ($25 min; $80 max)	20% ($50 min; $175 max)
Non-preferred brand-name (when no generic is available)	40% ($40 min; $110 max)	40% ($80 min; $225 max)
Specialty drug CVS Specialty Pharmacy	20% ($100 min; $150 max)	NA

HDHP Plan Prescription Benefits

Service	Retail	90-day supplies
Mandatory generic	Ded/$15	Ded/$30
Preferred brand-name* (when no generic is available)	Ded/20% ($25 min; $80 max)	Ded/20% ($50 min; $175 max)
Non-preferred brand-name (when no generic is available)	Ded/40% ($40 min; $110 max)	Ded/40% ($80 min; $225 max)
Specialty drug CVS Specialty Pharmacy	Ded/20% ($100 min; $150 max)	NA

Contact CVS Caremark

If you have any questions, call CVS Caremark at **1.866.475.7589** or visit **www.caremark.com**

Controlling your prescription copay

To get the most from your benefits plan, it pays to be a wise consumer. In many cases, you can control how much your share of costs will be when you fill a prescription. How? Generic drugs cost less to manufacture and they're just as effective as the name brands. You'll save money when you request them because generics have a lower copay than preferred or non-preferred drugs.

***Please note:** *If you purchase a brand-name drug while a generic is available, you will be charged the brand-name copay PLUS the cost difference between the generic and the brand-name drug.*

Whether you are most comfortable using your desktop, the mobile app on your smart phone, your laptop or your iPad, CVS Caremark can help you digitally manage your prescription benefits when you visit **caremark.com**:

- Check Drug Cost and Coverage
- Get Started with Delivery by Mail
- Easy Refills
- Manage Your Profile
- View ID Card
- Pharmacy Locator
- Find Opportunities to Save

The Performance Drug List (CVS)

Also called a formulary, the Performance Drug List is created by pharmacy experts and lists FDA-approved, safe, effective and economical drugs.

How the Performance Drug List works:

- Drugs are added to the list on a quarterly basis.
- Brand-name drugs can be removed at the end of the calendar year.
- Every January, the list is updated and available.
- If a generic becomes available, the brand-name drug will become a non-preferred drug, and may only be available for a higher copay.
- When a generic drug becomes available, you'll pay the lowest copay if you choose the generic.

Why generics make sense

Consider all of the compelling reasons to protect your pocketbook with the lower-price generic drugs:

- Generics can cost up to 75 percent less than their brand-name equivalents.
- FDA testing is exactly the same for generic and brand-name drugs.
- Generics contain the same active ingredients as the original, brand-name drug, in the same amounts and dosages.
- Generic drugs sometimes look different from the original brand-name drug in color or shape, but only because they may have different inactive ingredients that won't change how the drug works.
- Nearly half of all brand-name drugs have generic equivalents—but you may have to ask for them.
- Generics have the lowest copay under this plan, so you save on every prescription.

Maintenance drugs

In order to receive a three-month supply of maintenance prescriptions for just two copays you must choose to utilize the CVS Caremark mail order program or visit a CVS pharmacy retail location. If you choose to use any other retail pharmacy, you will only be permitted to fill your prescription for a 30 day supply and will not receive the additional copay savings. To enroll in the mail order program, call CVS Caremark at **1.866.475.7589** or go online at **www.caremark.com**.

ASBAIT Specialty Pharmacy

Specialty medications are unique and require extra attention and support. We have partnered with CVS Specialty Pharmacy to provide all ASBAIT members with a highly coordinated, efficient and flexible pharmacy solution for specialty medications.

CVS Specialty Pharmacy is the specialty pharmacy for all members of ASBAIT, whether you use the Banner Network or Aetna Choice POS II. It's a different kind of pharmacy. It does much more than just provide your medication; it also helps you manage your condition, as well as your health.

With CVS Specialty Pharmacy, you'll get the support of a dedicated care team led by pharmacists and nurses specially trained in your condition. You'll also have the choice to have your medications delivered anywhere nationwide or pick them up at any CVS Pharmacy® location. And they'll help you with insurance, handle your claims and find ways to keep your out-of-pocket costs low, too. Visit **www.CVSspecialty.com** to learn more.

If you take a specialty medication, don't hesitate to reach out to CVS Specialty Pharmacy at **1.800.237.2767** if you have any questions.

Use PrudentRx for savings on your Specialty Medications

The PrudentRx Program helps make it possible to get specialty medications at no out-of-pocket cost. The program works when you fill prescriptions at CVS Specialty Pharmacies on any covered specialty medication(s) on the plan's designated drug list, which can be located by calling **1.800.578.4403** (Mon-Fri 8:00 AM-8:00 PM, ET) or using **prudentrx.com**.

Effective, July 1, 2023 this program is available for *all* ASBAIT medical plans.

- You'll need to call the PrudentRx member advocates line to ensure proper registration and receive available copay cards.
- If you choose to opt out of this program, you'll be responsible for a 30 percent coinsurance payment on any medication currently eligible under the PrudentRx program.
- If you need help applying for a copay card, please contact the PrudentRx member advocate team at the number listed above.
- If you're enrolled in an HDHP plan and opt into PrudentRx, you will have to meet your plan's deductible prior to experiencing $0 out of pocket costs.

Appendix

In this section

- Glossary of terms
- Claims and customer service information
- Cost Estimator Tool
- Important contact information
- Banner|Aetna health centers and urgent care locations

Glossary of terms

Ambulatory surgery

Surgery performed at an ambulatory surgical facility (a licensed public or private facility), which does not provide services or accommodations for a patient to stay overnight.

Copay

An amount of money that a participant is required to pay each time he or she visits a health care provider or fills a prescription.

Deductible

The annual out-of-pocket amount that a plan participant is responsible for paying before the health plan covers his or her medical costs according to the terms of the plan. Until a person meets the annual deductible, he or she pays the full cost of health care services received, unless the service is not subject to the annual deductible as stated in the benefit schedule.

Your ASBAIT member website at Meritain Health

Your online health information website and your personal connection to your plan. Here you can order prescriptions, find health care providers, research health topics and get answers to your questions about health care. The personal information used to access **www.meritain.com** is confidential. You may need the information on your ID card to log in for the first time.

**See pages 17-18 for more information about our online tools.*

Provider network

Organization that negotiates special, lower rates for health care services provided by physicians and other care providers who are within the network. Providers who belong to a network are called participating or in-network providers.

Usual and customary charge

Your plan reimburses charges from non-participating or out-of-network providers that are equal to, or less than, usual and customary charges. Usual and customary charges are the amounts most frequently charged for the same service:

- In the same geographic area; and
- By other providers in the same or similar medical area.

The fees charged by non-participating providers may exceed the usual and customary charges recognized by your plan. In such cases, Meritain Health will process an amount equal to the usual and customary charge for the health care service you received, and you will be reimbursed for a portion of that amount according to your plan's out-of-network benefits.

Claims and customer service information

Balancing health care costs: What you pay and what the plan pays.

Your Summary of Benefits (SOB) shows how much you pay for care, and how much the plan pays. It's a listing of what is and isn't included in your benefits plan. For more detailed information, see your Summary Plan Document (SPD).

For example: After you pay your annual deductible and any up-front copays, the plan begins to pay a percentage of your provider's charges, for example 80 percent. The remaining percentage, for example 20 percent, is your responsibility—your "out-of-pocket" costs. You're protected from financial hardship by a maximum out-of-pocket amount each year—the most you'll have to pay before the plan covers costs at 100 percent.

Claims and customer service

Your ASBAIT claims are administered by Meritain Health. All claims adjudication and customer service inquiries are handled by Meritain Health staff members. Correspondence regarding your claims will be sent from our office. The goal of our Customer Service department is to ensure that school employees understand their plan features and receive immediate assistance regarding claims issues, from a highly-qualified and trained staff member. You will be treated with respect, as we are responsible to you for first call resolution with results. It is our goal to not only meet, but exceed your expectations. If you have any questions regarding your benefit plan(s) please contact Meritain Health Customer Service at **1.602.789.1170**, or toll free at **1.866.300.8449**.

Claim submission

You can submit your claims online using your the Meritain member website (**www.meritain.com**) and clicking on the submit claims tab **or** you can mail your claim forms and attachments to:

Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921

Cost Estimator Tool—Did you know?

The Transparency in Coverage Final Rule requires group health plans and health insurance carriers to disclose the enrolled member's cost-sharing liability for covered items or services on an internet website and in paper form (if requested).

The member self-service internet tool will include:

- Cost-sharing liability (deductible, co-insurance, etc.)
- Accumulated amounts
- Out-of-network allowed amount for the covered item or service
- Negotiated rate for in-network services
- Any prerequisite for the covered item or service

The tool is accessible through the Meritain Health member website (see how to access website on page 7). Members may also call the customer service number on their ID cards to request assistance. The tool provides 500 items and services that are prescribed in the regulations. The tool will eventually be expanded to include all covered items and services.

Important contact information

What do you need help with?	Who to contact	How to contact
My ASBAIT benefits	Meritain Health Customer Service	Call: **1.866.300.8449** or **1.602.789.1170** Visit: **http://www.meritain.com**
My prescription drug benefits	CVS Caremark	Call: **1.866.475.7589** Visit: **http://www.caremark.com**
Precertification	ASBAIT Medical Management	Call: **1.855.5ASBAIT** or **1.855.527.2248**
Employee Assistance Program (EAP)	Alliance Work Partners (AWP)	Call: **1.800.343.3822** Visit: **http://www.alliancewp.com**
Working~Well Wellness Program	Edwards Risk Management	Call: **1.800.575.2657**
Nurse Health Coaching	Meritain Health	Call: **1.855.527.2248**
Banner Nurse Now	Banner Health	Call: **1.602.747.7990** or **1.888.747.7990**
Health Savings Account (HSA) Information	Health Equity	Call: **1.877.694.3948** Visit: **http://healthequity.com/ed/asbait**
Specialty Pharmacy	CVS Specialty Pharmacy	Call: **1.800.237.2767** Visit: **www.CVSspecialty.com**
Skin health questions	SkinIO	Email: **help@skinio.com** Call: **1.855.754.6400**
Therapy for chronic pain	HINGE Health	Email: **hello@hingehealth.com** Call: **1.855.902.2777** Visit: **http://hingehealth.com/asbait**
24/7 Access to care	Teladoc Health	Call: **1.800.Teladoc (835.2362)** Visit: **http://teladoc.com**
Savings on specialty medications	PrudentRx	Call: **1.800.578.4403** Visit: **http://prudentrx.com**

Reach a Doctor 24/7

The Teladoc Health™ Solution

Teladoc Health is the on-demand health care solution that gives you the medical care you need, when you need it. You can talk to a doctor anytime, anywhere about non-emergent medical conditions.

Benefits of Teladoc Health:

- Saves time and money
- Quicker recovery from illness
- Convenient prescriptions
- Choice of consultation method
- Great health means peace of mind

With Teladoc Health, you can talk to a doctor 24/7/365 by phone, online video or mobile app. Use Teladoc Health for medical advice and care when:

- Your primary care doctor is not open.
- You are at home, traveling or do not want to take time off work to see a doctor.
- You need a prescription or refills*.

**Please note, there is no guarantee you will be prescribed medication.*

Highly qualified, experienced doctors

When you use Teladoc Health, your medical questions will be answered by a highly qualified doctor. Teladoc Health doctors are:

- Specially trained in telemedicine.
- Experienced—with an average of over 10–15 years in practice.
- Progressive—using the latest technology to provide excellent care.
- U.S. board-certified and state-licensed.

Our members love Teladoc Health

"We had a good experience with the doctor. She called and talked to me, and gave great service. I had no problem picking up my prescription. This is a really good service."

Common conditions treated:

- Allergies
- Bronchitis
- Cold/flu
- Headaches/migraine
- Eye/ear infection
- Rash/skin infections
- Sinus infections
- Stomach ache
- Urinary tract infections
- Many other conditions

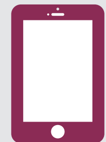
There's more than one way to reach a doctor

By phone.

Just call **1.800.835.2362**.

Online.

Simply request a video consultation online at **www.Teladoc.com**.



On the go.

You can download the Teladoc Health mobile app by visiting the App Store® or Google Play™.

How to register for Teladoc Health

You can use Teladoc Health anywhere you have internet access. Just:

1. Visit **www.Teladoc.com** and click *Set Up Account*.
2. Enter your name, date of birth, ZIP code, email address, preferred language and gender and click *Continue*. The system will identify you based on this information. If you're unable to be identified, you'll be directed to Teladoc Health Customer Service.
3. On the next screen, enter the required information and click *Set up my account*. Your registration is now complete!

Then, you can complete your profile by clicking on *My Medical History*. You can enter your history right after registering or you can come back to finish it later. By finishing it when you register, you'll be ready to request a consultation any time and you won't have to fill out your medical history when you're feeling sick.

If you have any questions, or run into any problems when setting up your account, call Teladoc Health at **1.800.TELADOC (1.800.835.2362)**.

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About the International Medical Solutions (IMS) Network

International Medical Solutions (IMS) provides quality and affordable health care for you and your family. With IMS, you have access to a large network of certified medical specialists and hospitals south of the border. IMS includes more than 650 medical, dental and vision providers along the U.S./Mexico border. During open enrollment, you can choose to add IMS to your benefits plan for just a $6 monthly access fee. Contact your district representative to find out more.

High-quality health care services

All IMS providers and facilities are quality-certified, so you know you're in good hands and receiving top-notch care. All doctors are members in good standing with the National College of Physicians in Mexico, and specialists are board certified. Clinics and hospitals must belong to the National Hospital Association in Mexico, and are chosen for their service to the community.

Affordable care when you need it

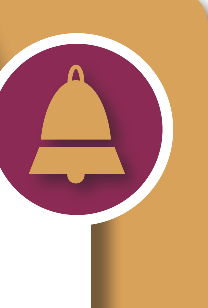
Cross-border care gives you and your family more access to care options, especially if the right providers aren't close by, or you're having trouble getting a timely appointment. IMS includes medical, dental and vision providers, plus emergency and urgent care services. IMS technology allows doctors to access enrollment and benefits verification 24 hours a day, so there's no red tape when you need an appointment.

Health care costs are lower in Mexico than in the U.S. That's why cross-border coverage helps you save on the cost of health care services for you and your family.

IMS medication program

If you have a chronic condition, you can enroll in the IMS medication program to receive up to a three-month supply of brand-name maintenance medication for just one copay. All medications are brand-name (no generics) and manufactured by laboratories including Pfizer-BioNTech, Lilly and Bayer.

Services offered by IMS



- Medical
- Dental
- Vision
- Pharmacy
- Medication program (long-term and maintenance)
- Free transportation
- MiDocOnline (telehealth)

Free transportation services

If you're in need of transportation, IMS offers free services to and from appointments, and to pick up medications. You can also get transportation to pick up your medications.

Questions? To learn more about the benefits provided under ASBAIT's IMS program or how to access care, please contact the IMS Customer Service department at:

International Medical Solutions
1.928.446.6179
inter-med-solutions@hotmail.com
www.internationalmedsolutions.com

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ASBAIT/INTERNATIONAL MEDICAL SOLUTIONS

FREQUENTLY ASKED QUESTIONS

ASBAIT and International Medical Solutions, Inc. (IMS) have put together these Frequently Asked Questions (FAQ) document for your reference.

How long has IMS been in business?

IMS has been in business since 2012.

What types of identification documents do I need to carry into Mexico to be able to travel in Mexico and to safely and easily return into the United States?

You will need a valid American passport, a picture ID or birth certificate; essentially any document that proves your American nationality. If you are bringing medication back into the United States with you, is very important to show your prescription to the Customs and Border Patrol Agents.

Will ASBAIT or IMS be issuing me a separate ID card for IMS's services? If so, will we get cards for each family member enrolled in the medical plan or do we get one (1) card per family?

International Medical Solutions provides one (1) ID card per family.

Is it legal to purchase and transport prescription medications filled in Mexico and if so, what should I know and what should I present to American Border Patrol personnel if requested?

It is legal to purchase prescription medications in Mexico as long as you have a prescription with you that supports your medical needs.

If you have questions that are not answered here, or need assistance about IMS or the benefits you will receive under ASBAIT's plan(s), please contact IMS at the phone number or address below:

International Medical Solutions
2671 4th Ave. Yuma, AZ 85366
Tel. 928 446 6179
Inter-med-solutions@hotmail.com
www.internationalmedsolutions.com

What types of medications can I get through the pharmacies and are those medications safe?

Under International Medical Solutions plan, only brand name medications produced by reputable and known drug manufacturers are covered; generic medications are not eligible under this plans.

Under this plan:

- Individuals importing the drug verify in writing that it is for his or her own personal use, and provides contact information for the doctor providing treatment or shows the product is for the continuation of treatment begun in a foreign country;
- The drug is considered not to represent an unreasonable risk.
- The drug is for use for a serious condition for which effective treatment is not available in the United States;
- There is no commercialization or promotion of the drug to U.S. residents.

Below is a link to help you to understand the FDA's requirement related to prescription drugs obtained in Mexico.

https://www.fda.gov/about-fda/fda-basics/it-legal-me-personally-import-drugs

Are generic medications available for purchase in Mexico under the IMS plan?

No, International Medical Solutions only covers brand name medications under which are manufactured by reputable and known drug manufacturers.

Are there any medications that I am prohibited from bringing across the border?

No, if you request or have any question about a specific drug please contact us.

Can I receive both inpatient and outpatient care in Mexico?

Yes, both of these types of services are available through the contracted International Medical Solutions provider network.

What care in Mexico is not covered under ASBAIT's medical plans?

The care and exclusions are the same as those under ASBAIT's plans. For more information about covered care and exclusions, please refer to ASBAIT's plan documents or contact ASBAIT's customer services department.

Does IMS provide any type of transportation into Mexico and if so, how far into Mexico will the transportation service take me?

The transportation service that we offer is exclusive for medical appointments, dental appointments and pharmacy trips. Please note that IMS will only provide transportation for services received at or near the border. You may still obtain care from contracted providers located deeper into Mexico, e.g., providers in Hermosillo, Sonora, but you will have to provide your own transportation to these destinations.

How quickly, typically, can I get a physician/dentist appointment in Mexico?

Primary Care Physician and General Dentistry appointments can be scheduled within 24 hours; appointments with specialists can take up to 3 days depending on the specialty.

If I need lab work, x-rays, other scan services, durable medical equipment, etc., in Mexico, who orders those?

Any diagnostic tests requested by your providers in México are available through International Medical Solutions contracted facilities and vendors.

If I have an order for the above services from a U.S. provider, will the Mexico facilities accept those or do those need to come directly from Mexico providers?

Yes, International Medical Solutions contracted providers can accept orders written by U.S. providers.

How far in advance of a visit into Mexico do I need to book an appointment with IMS's travel service?

24 hours if possible.

If I get care in Mexico, and want to share my medical history files with providers in the U.S., how do I go about requesting those?

Please request any recorders directly with International Medical Solutions.

Are Mexico providers generally cooperative when requesting these records?

Yes. Please be clear on your requests and to allow sufficient time for the provider to compile your records for you.

Are the (generally) any fees charged for record copies?

No.

Will Mexico providers work with U.S. providers to coordinate care?

Yes, contracted International Medical Solutions providers will work collaboratively with U.S. providers at their patients' request.

When scheduling appointments with providers in Mexico, what information will they be requesting and what information do we need to provide at our appointment?

Please be prepared to provide them with your full name, date of birth, district name and that you are enrolled under an International Medical Solutions plan.

How far into Mexico will I need to travel to get basic care?

Most contracted providers are located within close proximity to the U.S./Mexico border.

Do most, or any of the contracted providers speak English and how can I find out which do?

Most of International Medical Solutions contracted primary care physicians, specialists and dentists speak English or have staff that speak English. You may contact International Medical Solutions customer services department to get more information on which offices speak English.

Are the contracted hospitals or providers part of Mexico's national healthcare system or private providers?

All of International Medical Solutions contracted providers have private facilities and private hospitals.

Where and how do I get specific information about providers in Mexico, e.g., their subspecialties, where they studied, how long they have been practicing, if they are in good standing with their licensing agencies in Mexico, etc.?

If you are interested in obtaining specific schooling, subspecialty, licensing and credentialing information about contracted providers, you may contact International Medical Solutions customer service for this information.

Do Mexico providers carry malpractice insurance?

Yes, contracted surgeons and anesthesiologists do carry malpractice insurance.

Will the Mexico providers be submitting claims directly to ASBAIT/IMS for payment?

Contracted providers submit claims directly to International Medical Solutions and International Medical Solutions forwards them to ASBAIT for payment. This process ensures the accuracy of the claims being filed along with ensuring that services are verified and that the submitted charges are appropriate.

What do we do if we are charged something other than the copayment or deductible?

Please contact International Medical Solutions immediately to make them aware of any discrepancies.

Where do we submit any bills that we directly receive from providers?

Please contact International Medical Solutions right away so that we can assist you with the resolution of any claims issues or concerns.

If we are in the High Deductible Health Plan (HDHP/HSA), are non-medical vision services eligible to be paid under my HDHP's deductible? If not, can I use HSA funds to pay for any out-of-pocket costs?

Yes, HSA funds can be used to pay for qualified services, but claims for those services will not apply to your HDHP plan deductible. IMPORTANT REMINDER: When accessing any care in Mexico, it is important to use the International Medical Solutions contracted providers because care provided by non-contracted providers' services will not be recognized under these plans.

Will dental services be filed under my dental or medical plan?

If you are covered under one of ASBAIT's dental plans, then claims will be filed under that plan. If you are not enrolled under an ASBAIT dental plan, your claims will not be filed with another dental plan.

If you are not enrolled under one of ASBAIT's dental plan, you may still access care in Mexico and you will be required to pay the applicable fees charged by the Mexico dental provider, which in most cases, are much lower than costs in the U.S.

If you are not enrolled under an ASBAIT dental plan, and are enrolled in ASBAIT's Health Savings Account (HSA) plan, you can still use HSA funds to pay for services provided by International Medical Solutions contracted dentists but as mentioned earlier, these claims will not apply to your HDHP plan deductible.

If I have a problem with any care that I receive in Mexico, how do I go about resolving those issues?

International Medical Solutions customer service department can assist with any problems you may encounter.

How are medical/dental/vision/pharmacies providers selected to be part of IMS's network?

International Medical Solutions solicits well-known providers that are in good standing in their respective communities. Certificates and professional licenses are required and verified by International Medical Solutions before contracting with providers. Operating permits are granted by the Secretary of Health of México and medical licenses are issued by Mexico's Comisión Federal para la Protección contra Reisgos Sanitarios (COFEPRIS).

Are providers vetted and credentialed and if so by whom?

Certificates and professional licenses are required and verified by International Medical Solutions before contracting with providers. Operating permits are granted by the Secretary of Health of México and medical licenses are issued by Mexico's Comisión Federal para la Protección contra Reisgos Sanitarios (COFEPRIS).

Can I go into Mexico to visit and tour a doctor's office, dentist's office, hospital or pharmacy before deciding if I want to access care at one of these facilities?

Yes you may, and that can be arranged for you by contacting International Medical Solutions' customer service department which will assist you in doing so.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (866) 300-8449. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (866) 300-8449 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Tier 1 providers: $800 person / $1,600 family For Tier 2 providers: $1,000 person / $2,000 family For Tier 3 providers: $5,000 person / $15,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services as specified. For Tier 1 and Tier 2 provider services: office visits, durable medical equipment (diabetic supplies only), urgent care, inpatient facility fees, and free-standing lab are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Tier 1 providers: $4,800 person / $9,600 family For Tier 2 providers: $6,000 person / $12,000 family For Tier 3 providers: Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For Banner JV see www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers (You will pay the least)	Tier 2 Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$32 copay/visit	$40 copay/visit	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers. Copay applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. There is no charge, and the deductible does not apply if you receive consultation services through Teladoc.
	Specialist visit	$40 copay/visit	$50 copay/visit	50% coinsurance	
	Preventive care/ screening/ immunization	Preventive care: No Charge Routine care: No charge for the first $300 per year, then 90% coinsurance Flu, pneumonia and shingles immunization: No Charge Hearing exam: $32 copay	Preventive care: No Charge Routine care: No charge for the first $300 per year, then 90% coinsurance Flu, pneumonia and shingles immunization No Charge Hearing exam: $40 copay	Preventive care: Not Covered Routine care: No charge for flu, pneumonia and shingles immunizations Hearing exam: 50% coinsurance All other routine care: Not Covered	Deductible does not apply for Tier 1 and Tier 2 providers. Deductible does not apply for flu, pneumonia and shingles immunizations for Tier 3 providers. Hearing exams limited to 1 per year. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	25% coinsurance	50% coinsurance	Deductible does not apply for tests performed at a Tier 1 and Tier 2 providers freestanding laboratory.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	25% coinsurance	50% coinsurance	Preauthorization required for PET scans and non-orthopedic CT/MRI's. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Banner Providers (You will pay the least)	Tier 2 Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$15 copay (30-day retail)/ $30 copay (90-day retail & mail order)		Not Covered	Deductible does not apply. Covers up to a 30-day supply (retail prescription or specialty drugs); 90-day supply (retail prescription or mail order). Copay applies per prescription. Mandatory generic provision applies. There is no charge for preventive drugs. Diabetic insulin medications will have $5 copay (30-day retail) /$10 copay (90-day retail and mail order) for generic and $15 copay (30-day retail)/$30 copay (90-day retail and mail order) for brand name. Diabetic supplies will be paid the same as all other drugs (retail) and will have a $10 copay (mail order) for generic and $30 copay (mail order) for brand. Maintenance medications are subject to the retail or mail order supply limit and copays. Specialty drugs must be obtained directly from the specialty pharmacy. *Certain specialty drugs may be eligible for a $0 copay if you are enrolled under the PrudentRx Copay Program. If drugs are eligible under the Prudent Rx Copay Program and you do not enroll you will be subject to a 30% copay. Preauthorization required for injectables costing over $2,000 per drug per month.
	Preferred brand drugs	20% copay, ($25 minimum, $80 maximum) (30-day retail)/ 20% copay, ($50 minimum, $175 maximum) (90-day retail & mail order)		Not Covered	
	Non-preferred brand drugs	40% copay, ($40 minimum, $110 maximum) (30-day retail)/ 40% copay, ($80 minimum, $225 maximum) (90-day retail & mail order)		Not Covered	
	Specialty drugs	20% copay, ($100 minimum, $150 maximum)*		Not Covered	

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Banner Providers (You will pay the least)	Tier 2 Participating Providers	Tier 3 Non-Participating Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	25% coinsurance	50% coinsurance	Preauthorization required for certain surgeries, including infusion therapy costing over $2,000 per drug per month. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. See your plan document for a detailed listing. For Tier 1 office surgery under $1,000 cost is $32 copay/occurrence (PCP) or $40 copay/occurrence (specialist) with no deductible. For Tier 2 office surgery under $1,000 cost is $40 copay /occurrence (PCP) or $50 copay/ occurrence (specialist) with no deductible. Surgery over $1,000 cost is 25% coinsurance after deductible (PCP & specialist / Tier 1 & Tier 2).
	Physician/surgeon fees	25% coinsurance	25% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	25% coinsurance (emergency services)/ 50% coinsurance (non-emergency services)	Tier 2 & 3 providers are paid at the Tier 1 provider level of benefits for emergency services.
	Emergency medical transportation	25% coinsurance/trip (ground)/ $200 copay/trip + 25% coinsurance (air)	25% coinsurance/ trip (ground)/ $200 copay/trip + 25% coinsurance (air)	25% coinsurance /trip (ground)/ $200 copay/trip + 25% coinsurance (air)	Tier 2 & 3 providers are paid at the Tier 1 provider level of benefits.
	Urgent care	$50 copay/visit	$60 copay/visit	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/ admission + 25% coinsurance	$250 copay/ admission + 25% coinsurance	$300 copay/ admission + 50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 provider facility fees. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	25% coinsurance	25% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Banner Providers (You will pay the least)	Tier 2 Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$32 copay/visit (office visit)/ 25% coinsurance (all other outpatient)	$40 copay/visit (office visit)/ 25% coinsurance (all other outpatient)	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers office visit. Includes telemedicine other than Teladoc.
	Inpatient services	$200 copay/ admission + 25% coinsurance (facility charge)/ 25% coinsurance (professional fees)	$250 copay/ admission + 25% coinsurance (facility charge)/ 25% coinsurance (professional fees)	$300 copay/ admission + 50% coinsurance (facility charges)/ 50% coinsurance (professional fees)	Deductible does not apply for Tier 1 and Tier 2 provider facility fees. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
If you are pregnant	Office visits	25% coinsurance	25% coinsurance	50% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c- section). If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. Cost sharing does not apply to preventive services from a Tier 1/Tier 2 provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense. Deductible does not apply for Tier 1 and Tier 2 provider facility fees.
	Childbirth/delivery professional services	25% coinsurance	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$200 copay/ admission + 25% coinsurance	$250 copay/ admission + 25% coinsurance	$300 copay/ admission + 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	25% coinsurance	50% coinsurance	Limited to 60 visits per year. Home health care supplies not subject to the calendar year maximum. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Banner Providers (You will pay the least)	Tier 2 Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	Limitations, Exceptions, & Other Important Information
	Rehabilitation services	25% coinsurance (outpatient)/ $200 copay/admission + 25% coinsurance (inpatient)	25% coinsurance (outpatient)/ $250 copay/admission + 25% coinsurance (inpatient)	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers for inpatient services. Physical, speech & occupational therapy limited to 60 visits per each type of therapy per year. Inpatient services limited to 60 days per year.
	Habilitation services	Not Covered	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism and to expenses covered as preventive care.
	Skilled nursing care	$200 copay/ admission + 25% coinsurance	$250 copay/ admission + 25% coinsurance	$300 copay/ admission + 50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers. Limited to 60 days per 12 month period. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Durable medical equipment	$30 copay/item (diabetic supplies)/ 25% coinsurance (all other durable medical equipment)	$30 copay/item (diabetic supplies)/ 25% coinsurance (all other durable medical equipment)	50% coinsurance	Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. Deductible does not apply to diabetic supplies for Tier 1 and Tier 2 providers.
	Hospice services	$200 copay/ admission + 25% coinsurance (inpatient)/ 25% coinsurance (outpatient)	$250 copay/ admission + 25% coinsurance (inpatient)/ 25% coinsurance (outpatient)	$300 copay/ admission + 50% coinsurance (inpatient)/ 50% coinsurance (outpatient)	Deductible does not apply to services received on an inpatient basis from a Tier 1 and Tier 2 provider. Bereavement counseling is not covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's glasses	Not Covered	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Covered under stand alone dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Bereavement counseling • Cosmetic surgery • Dental care (covered under stand alone dental plan) • Glasses (covered under stand alone vision plan)	• Habilitation services (except autism & preventive services) • Infertility treatment (except diagnosis) • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing (except for home health care & hospice) • Routine eye care (covered under stand alone vision plan) • Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (for the treatment of morbid obesity only – 1 procedure per lifetime)	• Chiropractic care (20 visits per year)	• Hearing aids (1 aid per ear every 36 months)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov, or Meritain Health at (866) 300-8449. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Meritain Health, Inc. at (866) 300-8449.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-378-1179.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of Tier 1 pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$800**
- **Primary care physician coinsurance** **25%**
- **Hospital (facility) copayment** **$200**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Primary care physician visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,970

Managing Joe's Type 2 Diabetes

(a year of routine Tier 1 care of a well-controlled condition)

- **The plan's overall deductible** **$800**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$700
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,550

Mia's Simple Fracture

(Tier 1 emergency room visit and follow-up care)

- **The plan's overall deductible** **$800**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,300

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

MEDICAL SCHEDULE OF BENEFITS – VALUE SILVER BANNER 2023-2024

VALUE SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR DEDUCTIBLE			
Single	$800	$1,000	$5,000
Family	$1,600	$2,000	$15,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card)			
Single	$4,800	$6,000	Not Applicable
Family	$9,600	$12,000	Not Applicable
MEDICAL BENEFITS			
Allergy Serum and Injections	75% after Deductible	75% after Deductible	50% after Deductible
Ambulance Services			
Ground Ambulance Services	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Air Ambulance Services	$200 Copay per trip, then 75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Ambulatory Surgical Center	75% after Deductible	75% after Deductible	50% after Deductible
Anesthesiologist	75% after Deductible	75% after Deductible	50% after Deductible
Anti-Embolism Garments	75% after Deductible	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	3 pairs		
Cardiac Rehab (Outpatient)	75% after Deductible	75% after Deductible	50% after Deductible
Chemotherapy (Outpatient – includes all related charges)	75% after Deductible	75% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	100% after $32 Copay per visit; Deductible waived	100% after $40 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 visits		

VALUE SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diabetic Supplies	100% after $30 Copay per item; Deductible waived	100% after $30 Copay per item; Deductible waived	50% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)			
Any Single Service Costing Less Than $500	75% after Deductible	75% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	75% after Deductible	75% after Deductible	50% after Deductible
Freestanding Laboratory	75%; Deductible waived	75%; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	75% after Deductible	75% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	75% after Deductible	75% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	75% after Deductible	75% after Deductible	50% after Deductible
Emergency Services			
Emergency Medical Condition			
Facility Charges	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Professional Fees and Ancillary Charges	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Non-Emergency Medical Condition			
Facility Charges	75% after Deductible	75% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	75% after Deductible	75% after Deductible	50% after Deductible
Empower Health (TIN: 36-4836722)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: Empower Health wellness program is a voluntary wellness program available to the Employee only, Dependent Spouses and Children are not eligible. If you elect to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related choices. You will also be asked to complete a biometric screening, which will include a blood pressure reading and blood test. For more information regarding this program you may call Empower Health at (866) 367-6974.			
Foot Orthotics	$40 Copay per orthotic, then 75%; Deductible waived	$50 Copay per orthotic, then 75%; Deductible waived	$50 Copay per orthotic, then 50%; Deductible waived
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months		

VALUE SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	75% after Deductible	75% after Deductible	50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period		
Hemodialysis (Outpatient)	75% after Deductible	75% after Deductible	50% after Deductible
Hinge Health Program (TIN 81-1884841)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: Please refer to the Hinge Health Program section of this Plan for a more detailed description of this benefit. If treatment is received from providers outside of the Hinge Health Network, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.			
Home Health Care	75% after Deductible	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*		
*Home health care supplies are not subject to the Calendar Year Maximum.			
Hospice Care			
Inpatient	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	75% after Deductible	75% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	75% after Deductible	75% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.			
Infusion Therapy in Facility or Physician's Office	75% after Deductible	75% after Deductible	50% after Deductible

VALUE SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Maternity (Non-Facility Charges)*			
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	75% after Deductible	75% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.			
Medical and Surgical Supplies	75% after Deductible	75% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders			
Inpatient			
Facility Charge	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Fees	75% after Deductible	75% after Deductible	50% after Deductible
Outpatient Facility	75% after Deductible	75% after Deductible	50% after Deductible
Office Visits	100% after $32 Copay; Deductible waived	100% after $40 Copay; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.			
Morbid Obesity (Surgical Treatment Only)			
Facility (Inpatient and outpatient)	$200 Copay, then 75%; Deductible waived	$250 Copay, then 75%; Deductible waived	50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure		
Nutritional Food Supplements	50% after Deductible	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	75% after Deductible	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Pain Management	Paid based on place of service	Paid based on place of service	Paid based on place of service
Calendar Year Maximum Benefit	Not Applicable	Not Applicable	4 visits

VALUE SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physical Therapy (Outpatient)	75% after Deductible	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Physician's Services			
Inpatient/Outpatient Services			
Primary Care Physician	75% after Deductible	75% after Deductible	50% after Deductible
Specialist	75% after Deductible	75% after Deductible	50% after Deductible
Office Visits			
Primary Care Physician	100% after $32 Copay*; Deductible waived	100% after $40 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $40 Copay*; Deductible waived	100% after $50 Copay*; Deductible waived	50% after Deductible
Physician Office Surgery			
Primary Care Physician	Under $1,000 - 100% after $32 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	Under $1,000 - 100% after $40 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	50% after Deductible
Specialist	Under $1,000 - 100% after $40 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	Under $1,000 - 100% after $50 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			

VALUE SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care			
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	100%; Deductible waived	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% of the first $300 per Calendar Year, then 10%; Deductible waived	100% of the first $300 per Calendar Year, then 10%; Deductible waived	Not Covered
Flu, Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	100% after $32 Copay per exam; Deductible waived	100% after $40 Copay per exam; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam		
NOTE: Preventive prenatal and breastfeeding support are paid under the Maternity Benefit. Please see Maternity listed above for additional details.			
Prosthetics (other than bras)	75% after Deductible	75% after Deductible	50% after Deductible
Prosthetic Bras	75% after Deductible	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	2 bras		
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient - includes all related charges)	75% after Deductible	75% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 days		
Skilled Nursing Facility	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days		
SkinIO Provider (Skin Cancer Screenings)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: SkinIO is technology-based skin cancer screenings – providing access for early detection of skin cancer via photo-taking; remote dermatologist review; mole mapping; and change tracking and outlier detection for earlier detection for persons age 18 and over. TIN: 82-2035738			

VALUE SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Speech Therapy (Outpatient)	75% after Deductible	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Surgery (Inpatient)			
Facility	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include Surgery in the Physician's office)			
Facility	75% after Deductible	75% after Deductible	50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Teladoc Network Providers	Not Applicable	100%; Deductible waived	Not Applicable
Telemedicine			
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Temporomandibular Joint Dysfunction (TMJ)	$40 Copay per occurrence, then 75%; Deductible waived	$50 Copay per occurrence, then 75%; Deductible waived	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	 1 Surgical Procedure 1 appliance $1,000		

VALUE SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants			
Facility Charges	$200 Copay per admission, then 75%; Deductible waived (Aetna IOE Program)*	$250 Copay per admission, then 75%; Deductible waived (Aetna IOE Program)*	Not Covered
Professional Fees	75% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	75% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.			
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.			
Urgent Care Facility	$50 Copay* per visit, then 100%; Deductible waived	$60 Copay* per visit, then 100%; Deductible waived	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			
Wig (see Eligible Medical Expenses)	$40 Copay, then 75%; Deductible waived	$50 Copay, then 75%; Deductible waived	Paid at the Tier 2 level of benefits
Maximum Benefit per 24 Month Period	1 wig		
All Other Eligible Medical Expenses	75% after Deductible	75% after Deductible	50% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – VALUE SILVER BANNER 2023-2024

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical Out-of-Pocket) Single Family	 $6,000 $12,000
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	40% Copay ($40 minimum, $110 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications Generic Brand Diabetic Supplies Generic Brand	 $5 Copay $15 Copay $5 Copay $15 Copay
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through the PrudentRx Copay Program	20% Copay ($100 minimum, $150 maximum)
Enrolled and Available in the PrudentRx Copay Program	$0 Copay
Not Enrolled and Available in the PrudentRx Copay Program	30% Copay
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program.	
CVS Maintenance Choice – Allow Opt-Out: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Diabetic Insulin Medications Generic Brand Diabetic Supplies Generic Brand	 $10 Copay $30 Copay $10 Copay $30 Copay
Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications Generic Brand Diabetic Supplies Generic Brand	 $10 Copay $30 Copay $10 Copay $30 Copay

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense as Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS Maintenance Choice Mandatory – Allow Opt Out
The Plan allows for 2 30-day fills of maintenance drugs at any Participating retail pharmacy. After 2 fills, a 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy or through the mail order program unless you call the Prescription Drug Program Administrator and opt out. If you opt out, you may continue to purchase a 30-day supply of maintenance drugs, however, you will not benefit from the savings of a 90-day supply. For additional information, please contact the Prescription Drug Card Program Administrator.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (866) 300-8449. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (866) 300-8449 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Tier 1 providers: $400 person / $800 family For Tier 2 providers: $500 person / $1,000 family For Tier 3 providers: $1,400 person / $4,200 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services as specified. For Tier 1 and Tier 2 provider services: office visits, durable medical equipment (diabetic supplies only), urgent care, inpatient facility fees, free-standing lab and rehabilitation services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Tier 1 providers: $3,600 person / $7,200 family For Tier 2 providers: $4,500 person / $9,000 family For Tier 3 providers: Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For Banner JV see www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$24 copay/visit	$30 copay/visit	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers. Copay applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. There is no charge, and the deductible does not apply if you receive consultation services through Teladoc.
	Specialist visit	$32 copay/visit	$40 copay/visit	50% coinsurance	
	Preventive care/ screening/ immunization	Preventive care: No Charge Routine care: No charge for the first $300 per year, then 90% coinsurance Flu, pneumonia & shingles immunization: No Charge Hearing exam: $24 copay	Preventive care: No Charge Routine care: No charge for the first $300 per year, then 90% coinsurance Flu, pneumonia & shingles immunization: No Charge Hearing exam: $30 copay	Preventive care: Not Covered Routine care: No charge for flu, pneumonia & shingles immunizations Hearing exam: 50% coinsurance All other routine care: Not Covered	Deductible does not apply for Tier 1 and Tier 2 providers. Deductible does not apply for flu, pneumonia and shingles immunizations for Tier 3 providers. Hearing exams limited to 1 per year. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$24 copay/visit (freestanding lab)/ 20% coinsurance (all other lab locations & x-rays)	$30 copay/visit (freestanding lab)/ 20% coinsurance (all other lab locations & x-rays)	50% coinsurance	Deductible does not apply for tests performed at a Tier 1 and Tier 2 providers freestanding laboratory.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for PET scans and non-orthopedic CT/MRI's. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$15 copay (30-day retail)/ $30 copay (90-day retail & mail order)		Not Covered	Deductible does not apply. Covers up to a 30-day supply (retail prescription or specialty drugs); 90-day supply (retail prescription or mail order). Copay applies per prescription. Mandatory generic provision applies. There is no charge for preventive drugs. Diabetic insulin medications will have $5 copay (30-day retail) /$10 copay (90-day retail and mail order) for generic and $15 copay (30-day retail)/$30 copay (90-day retail and mail order) for brand name. Diabetic supplies will be paid the same as all other drugs (retail) and will have a $10 copay (mail order) for generic and $30 copay (mail order) for brand. Maintenance medications are subject to the retail or mail order supply limit and copays. Specialty drugs must be obtained directly from the specialty pharmacy. *Certain specialty drugs may be eligible for a $0 copay if you are enrolled under the PrudentRx Copay Program. If drugs are eligible under the Prudent Rx Copay Program and you do not enroll you will be subject to a 30% copay. Preauthorization required for injectables costing over $2,000 per drug per month.
	Preferred brand drugs	20% copay, ($25 minimum, $80 maximum) (30-day retail)/ 20% copay, ($50 minimum, $175 maximum) (90-day retail & mail order)		Not Covered	
	Non-preferred brand drugs	40% copay, ($40 minimum, $110 maximum) (30-day retail)/ 40% copay, ($80 minimum, $225 maximum) (90-day retail & mail order)		Not Covered	
	Specialty drugs	20% copay, ($100 minimum, $150 maximum)*		Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for certain surgeries, including infusion therapy costing over $2,000 per drug per month. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. See your plan document for a detailed listing. For Tier 1 office surgery under $1,000 cost is $24 copay/occurrence (PCP) or $32 copay/ occurrence (specialist) with no deductible. For Tier 2 office surgery under $1,000 cost is $30 copay/ occurrence (PCP) or $40 copay/ occurrence (specialist) with no deductible. Office surgery over $1,000 cost is 20% coinsurance after deductible (PCP & specialist/ Tier 1 & Tier 2).
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance (emergency services)/ 50% coinsurance (non-emergency services)	Tier 2 & 3 providers are paid at the Tier 1 provider level of benefits for emergency services.
	Emergency medical transportation	20% coinsurance/trip (ground)/ $200 copay/trip + 20% coinsurance (air)	20% coinsurance/ trip (ground)/ $200 copay/trip + 20% coinsurance (air)	20% coinsurance/ trip (ground)/ $200 copay/trip + 20% coinsurance (air)	Tier 2 & 3 providers are paid at the Tier 1 provider level of benefits.
	Urgent care	$42 copay/visit	$50 copay/visit	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission + 20% coinsurance	$250 copay/ admission + 20% coinsurance	$300 copay/ admission + 50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 provider facility fees. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Banner Providers (You will pay the least)	Tier 2 Participating Providers	Tier 3 Non-Participating Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$24 copay/visit (office visit)/ 20% coinsurance (all other outpatient)	$30 copay/visit (office visit)/ 20% coinsurance (all other outpatient)	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers office visit. Includes telemedicine other than Teladoc.
	Inpatient services	$200 copay/ admission + 20% coinsurance (facility charge)/ 20% coinsurance (professional fees)	$250 copay/ admission + 20% coinsurance (facility charge)/ 20% coinsurance (professional fees)	$300 copay/ admission + 50% coinsurance (facility charge)/ 50% coinsurance (professional fees)	Deductible does not apply for Tier 1 and Tier 2 provider facility fees. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. Cost sharing does not apply to preventive services from a Tier 1/Tier 2 provider. Depending on the type of services, a copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense. Deductible does not apply for Tier 1 and Tier 2 provider facility fees.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$200 copay/ admission + 20% coinsurance	$250 copay/ admission + 20% coinsurance	$300 copay/ admission + 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	50% coinsurance	Limited to 60 visits per year. Home health care supplies not subject to the calendar year maximum. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay: Tier 1 Banner Providers (You will pay the least)	Tier 2 Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	Limitations, Exceptions, & Other Important Information
	Rehabilitation services	$24 copay/visit (outpatient)/ $200 copay/admission + 20% coinsurance (inpatient)	$30 copay/visit (outpatient)/ $250 copay/admission + 20% coinsurance (inpatient)	50% coinsurance (outpatient)/ $300 copay/admission + 50% coinsurance (inpatient)	Deductible does not apply for Tier 1 and Tier 2 providers. Physical, speech & occupational therapy limited to 60 visits per each type of therapy per year. Inpatient services limited to 60 days per year.
	Habilitation services	Not Covered	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism and to expenses covered as preventive care.
	Skilled nursing care	$200 copay/ admission + 20% coinsurance	$250 copay/ admission + 20% coinsurance	$300 copay/ admission + 50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers. Limited to 60 days per 12 month period. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Durable medical equipment	$30 copay/item (diabetic supplies)/ 20% coinsurance (all other durable medical equipment)	$30 copay/item (diabetic supplies)/ 20% coinsurance (all other durable medical equipment)	50% coinsurance	Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. Deductible does not apply to diabetic supplies for Tier 1 and Tier 2 providers.
	Hospice services	$200 copay/ admission + 20% coinsurance (inpatient) / 20% coinsurance (outpatient)	$250 copay/ admission + 20% coinsurance (inpatient)/ 20% coinsurance (outpatient)	$300 copay/ admission + 50% coinsurance (inpatient)/ 50% coinsurance (outpatient)	Deductible does not apply to services received on an inpatient basis from a Tier 1 and Tier 2 provider. Bereavement counseling is not covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's glasses	Not Covered	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Covered under stand alone dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Bereavement counseling • Cosmetic surgery • Dental care (covered under stand alone dental plan) • Glasses (covered under stand alone vision plan)	• Habilitation services • Infertility treatment (except diagnosis) • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing (except for home health care & hospice) • Routine eye care (covered under stand alone vision plan) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (for the treatment of morbid obesity only – 1 procedure per lifetime)	• Chiropractic care (20 visits per year)	• Hearing aids (1 aid per ear every 36 months)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov, or Meritain Health at (866) 300-8449. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Meritain Health, Inc. at (866) 300-8449.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-378-1179.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-

Peg is Having a Baby
(9 months of Tier 1 pre-natal care and a hospital delivery)

- **The plan's overall deductible** $400
- **Primary care physician coinsurance** 20%
- **Hospital (facility) copayment** $200
- **Other copayment** 20%

This EXAMPLE event includes services like:
Primary care physician visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,070

Managing Joe's Type 2 Diabetes
(a year of routine Tier 1 care of a well-controlled condition)

- **The plan's overall deductible** $400
- **Specialist copayment** $32
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:
Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,120

Mia's Simple Fracture
(Tier 1 emergency room visit and follow-up care)

- **The plan's overall deductible** $400
- **Specialist copayment** $32
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$900

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

MEDICAL SCHEDULE OF BENEFITS – CLASSIC SILVER BANNER 2023-2024

CLASSIC SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR DEDUCTIBLE			
Single Family	$400 $800	$500 $1,000	$1,400 $4,200
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card)			
Single Family	$3,600 $7,200	$4,500 $9,000	Not Applicable Not Applicable
MEDICAL BENEFITS			
Allergy Serum & Injections			
Injections (If no office visit charge)	100% after $5 Copay per visit; Deductible waived	100% after $5 Copay per visit; Deductible waived	50% after Deductible
Serum	100% after $32 Copay per visit; Deductible waived	100% after $40 Copay per visit; Deductible waived	50% after Deductible
Ambulance Services			
Ground Ambulance Services	80% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Air Ambulance Services	$200 Copay per trip, then 80% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Ambulatory Surgical Center	80% after Deductible	80% after Deductible	50% after Deductible
Anesthesiologist	80% after Deductible	80% after Deductible	50% after Deductible
Anti-Embolism Garments	$40 Copay per pair, then 80%; Deductible waived	$50 Copay per pair, then 80%; Deductible waived	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs		
Cardiac Rehab (Outpatient)	100% after $24 Copay per visit; Deductible waived	100% after $30 Copay per visit; Deductible waived	50% after Deductible

CLASSIC SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Chemotherapy (Outpatient – includes all related charges)	80% after Deductible	80% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	100% after $24 Copay per visit; Deductible waived	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 visits		
Diabetic Supplies	100% after $30 Copay per item; Deductible waived	100% after $30 Copay per item; Deductible waived	50% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)			
Any Single Service Costing Less Than $500	80% after Deductible	80% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	80% after Deductible	80% after Deductible	50% after Deductible
Freestanding Laboratory	100% after $24 Copay; Deductible waived	100% after $30 Copay; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	80% after Deductible	80% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible	80% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	80% after Deductible	50% after Deductible
Emergency Services			
Emergency Medical Condition			
Facility Charges	80% after Deductible	Paid at the Tier 1 level of benefits	Paid at the Tier 1 level of benefits
Professional Fees and Ancillary Charges	80% after Deductible	Paid at the Tier 1 level of benefits	Paid at the Tier 1 level of benefits
Non-Emergency Medical Condition			
Facility Charges	80% after Deductible	80% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	80% after Deductible	80% after Deductible	50% after Deductible
Empower Health (TIN: 36-4836722)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: Empower Health wellness program is a voluntary wellness program available to the Employee only, Dependent Spouses and Children are not eligible. If you elect to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related choices. You will also be asked to complete a biometric screening, which will include a blood pressure reading and blood test. For more information regarding this program you may call Empower Health at (866) 367-6974.			

CLASSIC SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Foot Orthotics	$40 Copay per orthotic, then 80%; Deductible waived	$50 Copay per orthotic, then 80%; Deductible waived	$50 Copay per orthotic, then 50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months		
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	80% after Deductible	80% after Deductible	$50 Copay, then 50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period		
Hemodialysis (Outpatient)	80% after Deductible	80% after Deductible	50% after Deductible
Hinge Health Program (TIN 81-1884841)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: Please refer to the Hinge Health Program section of this Plan for a more detailed description of this benefit. If treatment is received from providers outside of the Hinge Health Network, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.			
Home Health Care	80% after Deductible	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*		
*Home health care supplies are not subject to the Calendar Year Maximum.			
Hospice Care			
Inpatient	$200 Copay per admission, then 80%; Deductible waived	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	80% after Deductible	80% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	$200 Copay per admission, then 80%; Deductible waived	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	80% after Deductible	80% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.			
Infusion Therapy in Facility or Physician's Office	80% after Deductible	80% after Deductible	50% after Deductible

CLASSIC SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Maternity (Non-Facility Charges)*			
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.			
Medical and Surgical Supplies	80% after Deductible	80% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders			
Inpatient			
Facility Charge	$200 Copay per admission, then 80%; Deductible waived	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Fees	80% after Deductible	80% after Deductible	50% after Deductible
Outpatient Facility	80% after Deductible	80% after Deductible	50% after Deductible
Office Visits	100% after $24 Copay; Deductible waived	100% after $30 Copay; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.			
Morbid Obesity (Surgical Treatment Only)			
Facility (Inpatient and outpatient)	$200 Copay, then 80%; Deductible waived	$250 Copay, then 80%; Deductible waived	50% after Deductible
Professional Services	80% after Deductible	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure		
Nutritional Food Supplements	50% after Deductible	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	100% after $24 Copay per visit; Deductible waived	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		

CLASSIC SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Pain Management	Paid based on place of service	Paid based on place of service	Paid based on place of service
Calendar Year Maximum Benefit	Not Applicable	Not Applicable	4 visits
Physical Therapy (Outpatient)	100% after $24 Copay per visit; Deductible waived	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Physician's Services			
Inpatient/Outpatient Services			
Primary Care Physician	80% after Deductible	80% after Deductible	50% after Deductible
Specialist	80% after Deductible	80% after Deductible	50% after Deductible
Office Visits			
Primary Care Physician	100% after $24 Copay*; Deductible waived	100% after $30 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $32 Copay*; Deductible waived	100% after $40 Copay*; Deductible waived	50% after Deductible
Physician Office Surgery			
Primary Care Physician	Under $1,000 – 100% after $24 Copay*; Deductible waived; $1,000 or more – 80% after Deductible	Under $1,000 – 100% after $30 Copay*; Deductible waived; $1,000 or more – 80% after Deductible	50% after Deductible
Specialist	Under $1,000 – 100% after $32 Copay*; Deductible waived; $1,000 or more – 80% after Deductible	Under $1,000 – 100% after $40 Copay*; Deductible waived; $1,000 or more – 80% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			

CLASSIC SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care			
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	100%; Deductible waived	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% of the first $300 per Calendar Year, then 10%; Deductible waived	100% of the first $300 per Calendar Year, then 10%; Deductible waived	Not Covered
Flu Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	100% after $24 Copay per exam; Deductible waived	100% after $30 Copay per exam; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam		
NOTE: Preventive prenatal and breastfeeding support are paid under the Maternity Benefit. Please see Maternity listed above for additional details.			
Prosthetics (other than bras)	80% after Deductible	80% after Deductible	50% after Deductible
Prosthetic Bras	80% after Deductible	80% after Deductible	80% after Deductible
Calendar Year Maximum Benefit	2 bras		
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient - includes all related charges)	80% after Deductible	80% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	$200 Copay per admission, then 80%; Deductible waived	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days		
Skilled Nursing Facility	$200 Copay per admission, then 80%; Deductible waived	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days		

CLASSIC SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
SkinIO Provider (Skin Cancer Screenings)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: SkinIO is technology-based skin cancer screenings – providing access for early detection of skin cancer via photo-taking; remote dermatologist review; mole mapping; and change tracking and outlier detection for earlier detection for persons age 18 and over. TIN: 82-2035738			
Speech Therapy (Outpatient)	100% after $24 Copay per visit; Deductible waived	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Surgery (Inpatient)			
Facility	$200 Copay per admission, then 80%; Deductible waived	$250 Copay per admission, then 80%; Deductible waived	50% after Deductible
Professional Services/Ancillary	80% after Deductible	80% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include Surgery in the Physician's office)			
Facility	80% after Deductible	80% after Deductible	50% after Deductible
Professional Services/Ancillary	80% after Deductible	80% after Deductible	50% after Deductible
Teladoc Network Providers	Not Applicable	100%; Deductible waived	Not Applicable
Telemedicine			
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Temporomandibular Joint Dysfunction (TMJ)	$40 Copay per occurrence, then 80%; Deductible waived	$50 Copay per occurrence, then 80%; Deductible waived	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	 1 Surgical Procedure 1 appliance $1,000		

CLASSIC SILVER BANNER 2023-2024	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants			
Facility Charges	$200 Copay per admission, then 80%; Deductible waived (Aetna IOE Program)*	$250 Copay per admission, then 80%; Deductible waived (Aetna IOE Program)*	Not Covered
Professional Fees	80% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	80% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.			
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.			
Urgent Care Facility	$42 Copay* per visit, then 100%; Deductible waived	$50 Copay* per visit, then 100%; Deductible waived	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			
Wig (see Eligible Medical Expenses)	$40 Copay per wig, then 80%; Deductible waived	$50 Copay per wig, then 80%; Deductible waived	$50 Copay per wig, then 80%; Deductible waived
Maximum Benefit per 24 Month Period	1 wig		
All Other Eligible Medical Expenses	$40 Copay*, then 80%; Deductible waived	$50 Copay*, then 80%; Deductible waived	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.			

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CLASSIC SILVER BANNER 2022-2023

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical Out-of-Pocket)	
Single	$4,500
Family	$9,000
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	40% Copay ($40 minimum, $110 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications	
Generic	$5 Copay
Brand	$15 Copay
Diabetic Supplies	
Generic	$5 Copay
Brand	$15 Copay
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through the PrudentRx Copay Program	20% Copay ($100 minimum, $150 maximum)
Enrolled and Available in the PrudentRx Copay Program	$0 Copay
Not Enrolled and Available in the PrudentRx Copay Program	30% Copay
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program.	
CVS Maintenance Choice – Allow Opt-Out: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Diabetic Insulin Medications Generic Brand Diabetic Supplies Generic Brand	 $10 Copay $30 Copay $10 Copay $30 Copay
Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications Generic Brand Diabetic Supplies Generic Brand	 $10 Copay $30 Copay $10 Copay $30 Copay

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense as Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS Maintenance Choice Mandatory – Allow Opt Out
The Plan allows for 2 30-day fills of maintenance drugs at any Participating retail pharmacy. After 2 fills, a 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy or through the mail order program unless you call the Prescription Drug Program Administrator and opt out. If you opt out, you may continue to purchase a 30-day supply of maintenance drugs, however, you will not benefit from the savings of a 90-day supply. For additional information, please contact the Prescription Drug Card Program Administrator.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Advanced Control Specialty Formulary
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

PrudentRx Copay Program for Specialty Medications
Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Copay Program will assist individuals in obtaining copay assistance from drug manufacturers to reduce an individual's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible persons will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications, in that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copays for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count towards your Out-of-Pocket Maximum. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

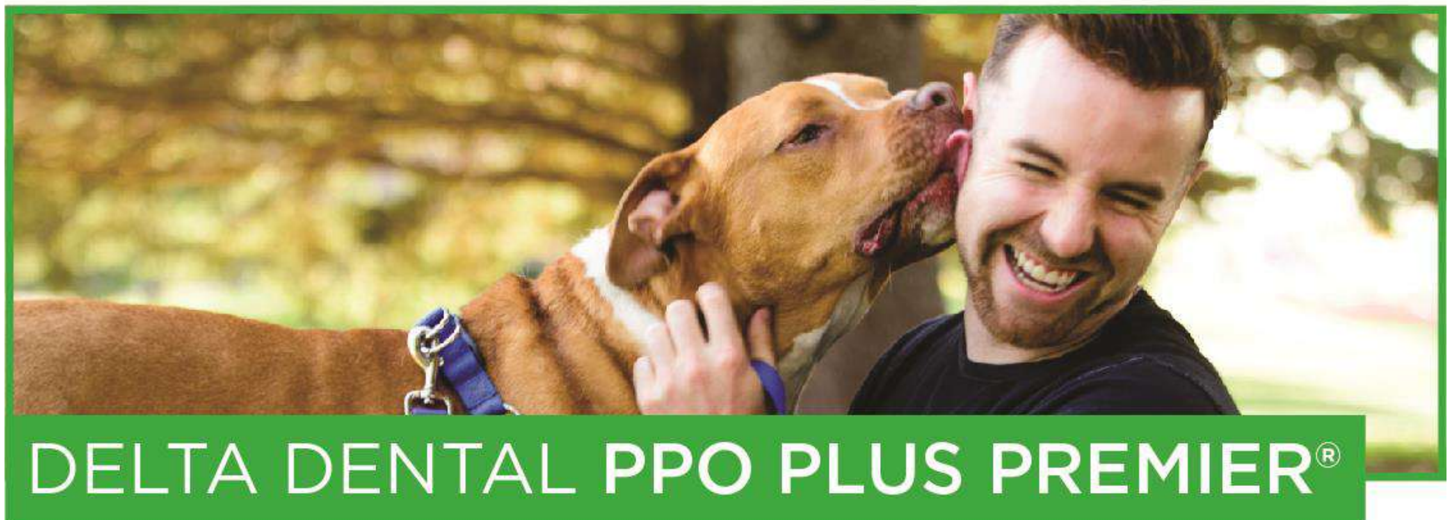
https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Dental

INSURANCE

Delta Dental of Arizona
DeltaDentalAZ.com



DELTA DENTAL **PPO PLUS PREMIER®**

UNLEASH YOUR SMILE POWER™

Why Go PPO

You may visit any licensed dentist, but you will save the most money by visiting a PPO dentist. That's because PPO dentists agree to accept lower reimbursements for services.

Out-of-network dentist

Premier dentist

PPO dentist

Find A Dentist

It's easy to find a Delta Dental dentist near you with our provider search tool at **deltadentalaz.com** or in the Delta Dental Mobile App.

Easy Benefits Coordination

If you're covered under two plans, ask your dentist to include information about both plans with your claim, and we'll handle the rest.

No ID Card Necessary

Just give your dental office your name and member ID. Don't know your member ID? Pull up an electronic ID card on your smartphone at the dentist's office by logging in to the Delta Dental Mobile App.

Download The Mobile App

Access your benefits and view your ID card on-the-go with the Delta Dental Mobile App. It's free for Android and iOS!

Know Your Coverage

New to the Delta Dental PPO plan? This plan covers treatment started and completed after your plan's effective date of coverage.[1] Your benefit summary and benefit booklet have specific details about covered treatments.

Register Online

Sign up for the Member Connection at **deltadentalaz.com/member** to view benefits, eligibility and claims status or to check average dental costs in your area. You can also update your delivery preference for dental benefits statements (EOBs) and go paperless!

Understand Common Dental Terms

It's our goal to make your benefits simple to use and easy to understand. Here are some common terms defined:

- **Annual Maximum** – The maximum dollar amount Delta Dental will pay toward the cost of dental care within a specific benefit period.
- **Deductible** – The amount you pay for covered dental services before Delta Dental begins to pay.
- **Coinsurance** – The percentage of dental care expenses you pay after your deductible.
- **Predetermination** – A pre-treatment estimate that helps determine the cost of a recommended dental treatment.

[1] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier will be responsible for any costs. Group-specific and other exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment. Refer to your benefit booklet for specific details about your plan.

RIVERSIDE SCHOOL DISTRICT NO. 2
Effective Date: 07/01/2020
Plan Name: Delta Dental PPO plus Premier®
Group # 4913
Your benefits are based on a Calendar Year

DELTA DENTAL PPO PLUS PREMIER®

Covered Services	PPO Dentist, Premier® Dentist and Out-of-Network Dentist [1]
Calendar Year Maximum Benefit (Combination of in and out-of-network)	$1,500
Calendar Year Deductible (Individual/Family) (Combination of in and out-of-network)	$50/150
Lifetime Orthodontia Maximum (Combination of in and out-of-network)	Child $1,500
Preventive Services (**Does not apply toward the Annual Maximum Benefit**)	*Delta Dental Pays*
Exams	100%
Routine Cleanings	
Fluoride: For children to age 18	
Sealants: For children up to age 19	
X-rays	
Space Maintainers	
Basic Services	*Delta Dental Pays*
Fillings	80% [2]
Emergency Treatment	
Endodontics: Root canal treatment	
Periodontics: Treatment of gum disease	
Oral Surgery: Simple extractions.	
Oral Surgery: Surgical extractions.	
Major Services	*Delta Dental Pays*
Prosthodontics: Bridges, partial dentures, complete dentures	50% [2]
Bridge and Denture Repair	
Implants	
Restorative: Crowns and onlays	
Orthodontic Services	*Delta Dental Pays*
Benefit for children ages 8-19. Children must be banded prior to age 17.	50%

[1] Members may incur higher out-of-pocket costs when seeing a Premier or out-of-network dentist. See Covered Dental Services sheet.
[2] Deductible applies to these services.

BENEFITS ARE SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE GROUP CONTRACT
Dependent Age Limit: 26 | Predetermination recommended for services over $250.

How Can We Help You?

Member Connection
deltadentalaz.com/member

Find A Dentist
deltadentalaz.com/provider-search

Customer Service
602.938.3131, option 1
800.352.6132, option 1

RIVERSIDE SCHOOL DISTRICT NO. 2
Effective Date: 07/01/2020
Plan Name: Delta Dental PPO plus Premier®
Group # 4913
Your benefits are based on a Calendar Year

COVERED DENTAL SERVICES

PREVENTIVE SERVICES

- Exams, evaluations or consultations: Two in a benefit year.
- Routine Cleanings: Limited to two in a benefit year. One difficult cleaning may be exchanged for one routine cleaning. However, the difficult cleaning is limited to once in a 5-year period.
- Topical Application of Fluoride: For children to age 18 - Two in a benefit year.
- Sealants: For children up to age 19 - Once in a 3-year period for permanent molars and bicuspids.
- Full mouth/Panorex or vertical bitewings X-rays: Once in a 3-year period.
- Bitewing X-rays: Two in a benefit year.
- Periapical X-rays: As needed.
- Space Maintainers: For missing posterior primary (baby) teeth up to age 14.

BASIC SERVICES **(Deductible applies to these services.)**

- Fillings: Silver amalgam and for front teeth only, synthetic tooth color fillings. One per surface every two years.
- Emergency (Palliative Treatment): Treatment for the relief of pain.
- Endodontics: Root canal treatment (permanent teeth). Pulpotomy primary (baby) teeth.
- Periodontics: Treatment of gum disease - Non-surgical once every two years. Surgical once every three years.
- Oral Surgery: Simple extractions.
- Oral Surgery: Surgical extractions.

MAJOR SERVICES **(Deductible applies to these services.)**

- Prosthodontics: Bridges, partial dentures, complete dentures - 5-year waiting period for replacement last performed.
- Bridge and Denture Repair: Repair of such appliances to their original condition, including relining of dentures.
- Implant- Implants are only a benefit to replace a single missing tooth once in a five (5) year interval from the date the procedure was last performed.
- Restorative: Crowns and onlays - 5-year waiting period for replacement last performed.

ORTHODONTIC SERVICES

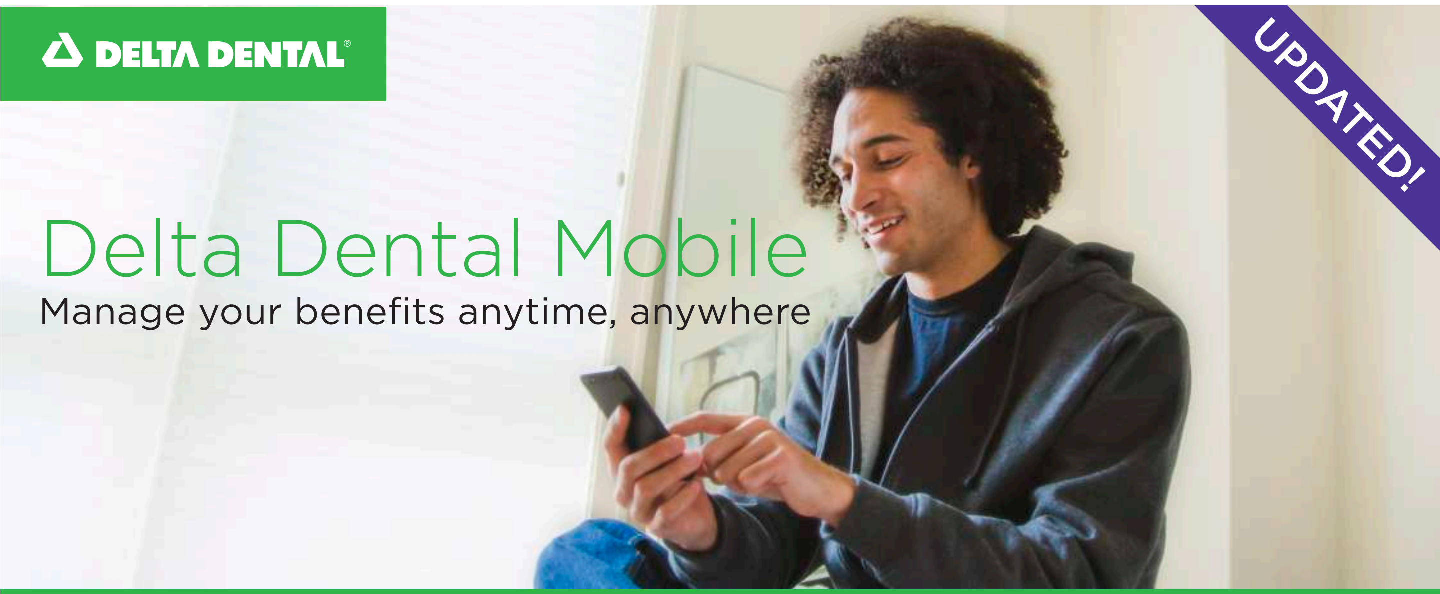
- Benefit for children ages 8-19. Children must be banded prior to age 17. Payable in two payments - upon initial banding and 12 months after. The orthodontic maximum is separate from the annual maximum for your other dental benefits.

DENTIST PAYMENTS

The **Delta Dental PPO plus Premier plan** leverages the PPO and Premier networks. This provides all the benefits of Delta Dental PPO plan with a plus-members that visit a dentist in the Premier network still receive the benefit of that dentist's contracted fee.

- **PPO Dentist** -- These in-network dentists agreed to accept lower reimbursement for services so members save the most money.
- **Premier Dentist** -- These in-network dentists also accept discounted reimbursement for services, but their discount is not as steep.
- **Out-of-Network Dentist** -- These dentists have not agreed to discount their rates for service, so members who see an out-of-network dentist will have the highest out-of-pocket costs. Members are responsible for paying the full fee charged by the dentist and can submit for reimbursement at the non-participating table of allowance.

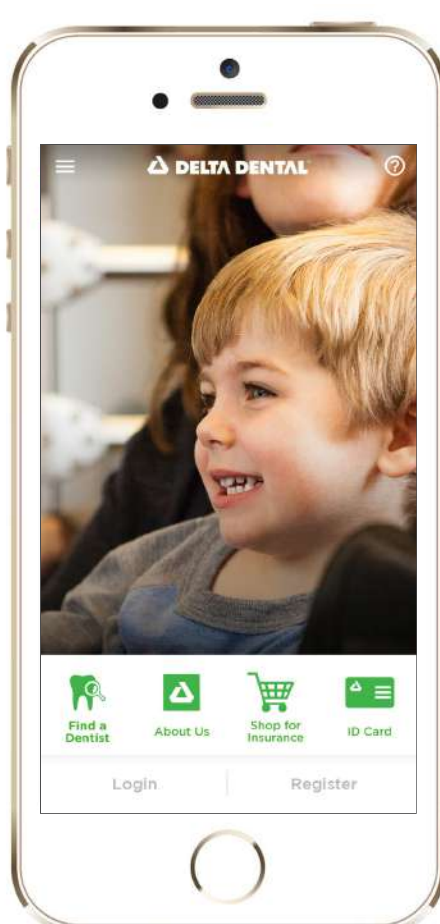
BENEFITS ARE SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE GROUP CONTRACT



Delta Dental Mobile

Manage your benefits anytime, anywhere

Your dental health is important to Delta Dental – and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Access dentist search, check claims and coverage, view ID cards and more, right on your mobile device.



Getting Started

Delta Dental's mobile app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, scan the QR code at right. You will need an internet connection in order to download and use most features of our free app.

SCAN TO DOWNLOAD DELTA DENTAL MOBILE

Using the App Without Logging In

Anyone can use Delta Dental Mobile without logging in to access our Dentist Search, Toothbrush Timer, LifeSmile Score risk assessment and Cost Estimator.

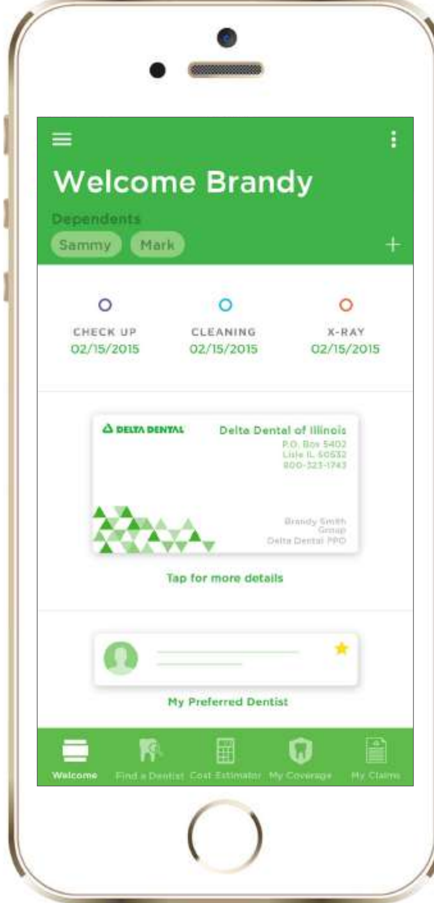
Logging In to View Benefits

Delta Dental members can log in using the username and password they use to log in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via Delta Dental Mobile.

Delta Dental Mobile Features

UPDATED!

Log in to access the full range of tools and resources



Mobile ID Card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.

My Coverage and My Claims

View information on your plan and coverage details, and check the status of claims for you and your family. Easily add your dependents to your account so you can access the whole family's coverage in one spot.

Find a Dentist

It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.

Schedule Dental Appointments*

View and select open appointment times with participating dentists, making scheduling dental appointments more convenient than ever. (Powered by Brighter Schedule™)

Dental Care Cost Estimator*

Find out what to expect with our Dental Care Cost Estimator. Our easy to use tool provides estimated cost ranges on common dental care needs for dentists in your area. You can even select your dentist for tailored cost estimates.

LifeSmile Score

Do you know how your smile scores? Learn more about your personal oral health risk profile by taking our simple risk assessment survey.

Toothbrush Timer

Help your family keep up with their oral health routine by using this handy tool. Our timer counts down for two minutes while reminding you to brush each tooth.

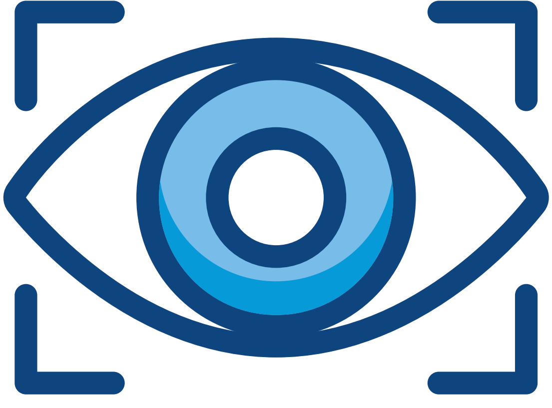
*Feature not available in all geographic areas and is subject to dentist participation.

Secure Access to Your Benefits

You must log in each time you access the secure portion of the app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed by clicking the lock icon on the main menu.

Information displayed may vary based on your particular coverage. For more information on your coverage, contact Delta Dental of Arizona.

Vision
INSURANCE



DELTA DENTAL

GOLD PLAN - INSIGHT NETWORK

Benefits Snapshot

KNOW YOUR BENEFITS

You're on the Insight network

For a complete list of providers near you, use our Provider Locator on EyeMedVisionCare.com

For LASIK providers, call 1.877.5LASER6

For customer service, call 866.800.5457

THERE'S MORE SAVINGS

40% off additional pairs of prescription eyeglasses or sunglasses[7]

20% off non-prescription sunglasses[7]

These discounts are for in-network providers only

Vision Care Service	In-network	Out-of-network[1]
Vision Exam With Dilation (As necessary)	$10 copay	$30
Retinal Imaging	Up to $39	N/A
Contact Lens Fit & Follow-up		
Standard Fit & Follow-up	Up to $55	N/A
Premium Fit & Follow-up	10% off retail price	N/A
Frames	$0 copay; $120 allowance, 20% off balance over $120	$60
Standard Plastic Lenses		
Single Vision	$10 copay	$25
Bifocal	$10 copay	$40
Trifocal	$10 copay	$55
Lenticular	$10 copay	$55
Standard Progressive Lens[2]	$75 copay	$40
Premium Progressive Lens[2]	**Tier 1:** $95 copay **Tier 2:** $105 copay **Tier 3:** $120 copay **Tier 4:** $75 copay, 80% of charge less $120 allowance	$40
Lens Options		
UV Coating	$15	N/A
Tint (Solid and gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Anti-Reflective[2]	$45	N/A
Polarized	20% off retail price	N/A
Photocromatic/Transitions Plastic[2]	$75	N/A
Premium Anti-reflective	**Tier 1:** $57 **Tier 2:** $68 **Tier 3:** 80% of charge	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses[3]		
Conventional	$0 copay; $80 allowance, 15% off balance over $80	$64
Disposable	$0 copay; $80 allowance, plus balance over $80	$64
Medically Necessary	$0 copay, paid-in-full	$200
Lasik and PRK Benefit	15% off retail price or 5% off promotional price	N/A
Diabetic Care Services[4]		
Office Service Visit (Medical follow-up exam)	Covered 100%, $0 copay	$77
Fundus Photography[5]		$50
Extended Opthamaloscopy[6]		$15
Gonioscopy		$15
Scanning Laser		$33
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Diabetic Care Services	Up to 2 services per benefit year	

[1]Out-of network reimbursement will be the lesser of the listed amount or the member's actual cost from the out-of-net work provider. In certain states, members may be required to pay the full retail rate and not the negotiated retail discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which providers have agreed to the discounted rate.

[2]Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. EyeMed reserves the right to make changes to the products on each tier and the mem ber out-of-pocket costs. Contact EyeMed for a current listing of brands by tier.

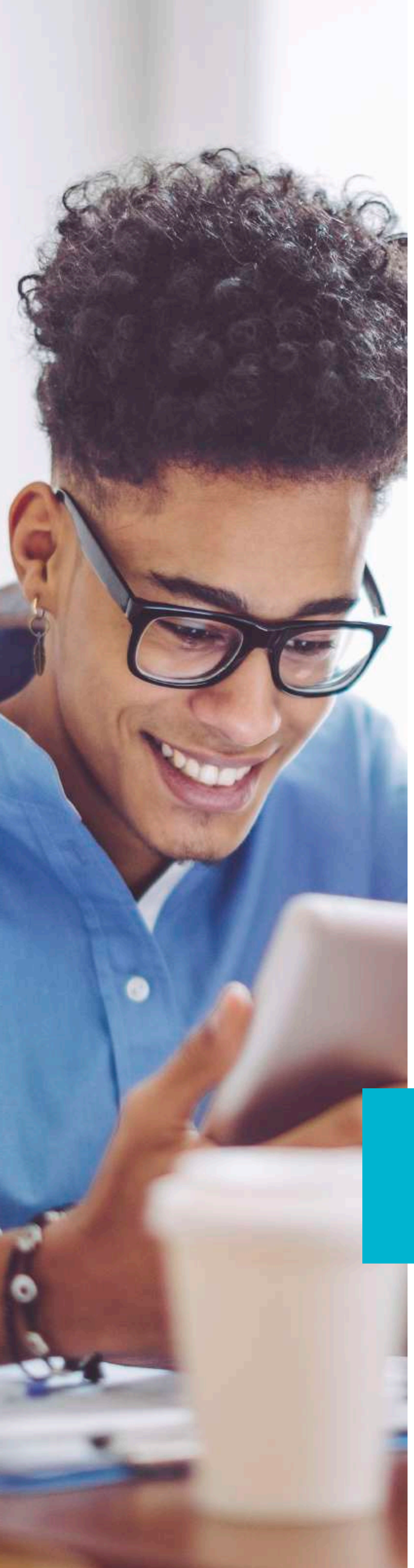
[3]Contact lens allowance includes materials only.

[4]Diabetic care services cover diabetic eye care evaluation services only for members with Type 1 or Type 2 diabetes. Exclusions and limitations may apply. Refer to plan details for coverage specifics.

[5]Not covered if extended ophthalmoscopy is provided within 6 months.

[6]Not covered if fundus photography is provided within 6 months.

[7]Not insured benefits. Discounts on non-covered services may not be available at all providers or locations.



Welcome to DeltaVision! We've made it easier than ever to access your vision benefit information and schedule your annual eye exam. Everything you need is available through our member vision portal.

Here's How It Works

Follow these simple steps to access and use your DeltaVision benefits:

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

Finding a Provider

Log in to the vision portal and select "Locate a Provider." You may need to select your network (Insight). Enter your zip code to be connected with eye health experts near you.

Questions?

Feel free to contact our award-winning Customer Care Center[2] at 866.800.5457.

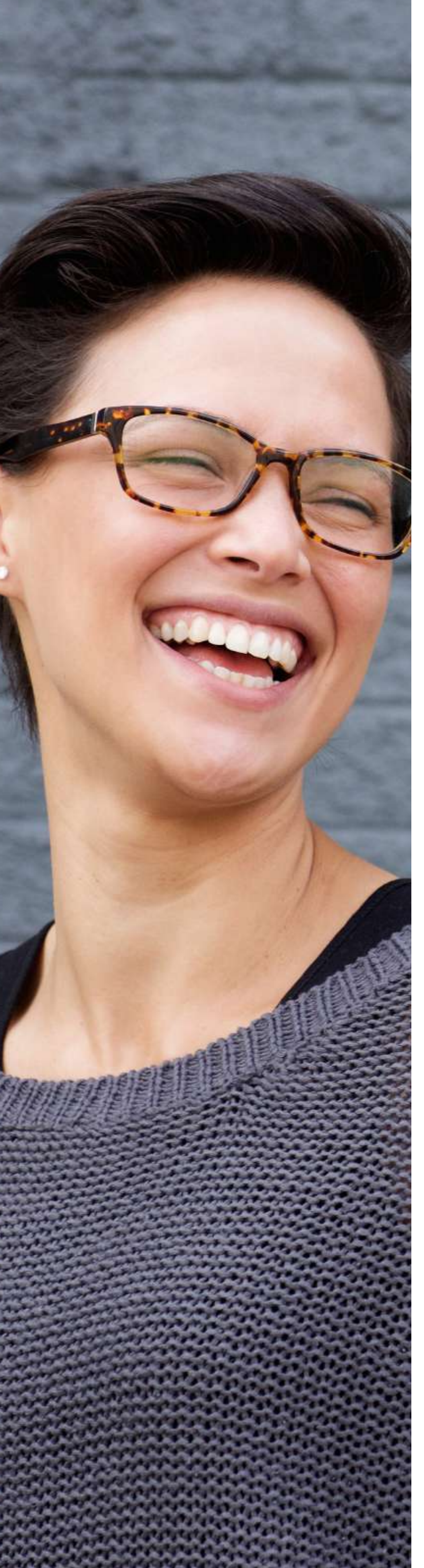
Did You Know...

You can receive services even if you don't have your ID card. Just provide your name and birthdate so the office can verify your vision benefits.

[1]Actual benefits and frequencies vary by plan.
[2]Purdue University BenchmarkPortal independent assessment of call centers nationwide.

PDF-1609-R-538

Arizona Dental Insurance Service, Inc. dba Delta Dental of Arizona. EM-0014-rev0517
Delta Dental of Arizona complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-602-588-3131 (TTY: 1-602-588-3903).
Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-602-588-3131 (TTY: 1-602-588-3903).



With DeltaVision administered by EyeMed, you:

- Have access to one of the nation's largest networks of independent eye doctors and national retail and regional retail providers.
- Receive care when it's convenient for you—with extended weeknight and weekend hours and online appointment scheduling.
- Can use Glasses.com and ContactsDirect.com as in-network providers to easily find and purchase glasses and contacts—all shipped directly to your front door.
- Have tools and resources that make using your benefit an experience you'll appreciate:
  - Enhanced provider searches to find the right provider
  - Optimized web and mobile resources
  - Award-winning, customer care available day and night

Plus...

40% off additional pairs of glasses or prescription sunglasses[1]

20% off any remaining balance over the frame allowance[2]

20% off non-prescription sunglasses[2]

[1] Available at in-network provider locations

[2] Not insured benefits. Discounts on non-covered services may not be available through all providers or in all stores

PDF-1609-R-543

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Life
INSURANCE

Summary of Benefits

Riverside School District #2

All Employees

Basic Term Life, Basic Accidental Death & Dismemberment, Optional Term Life, Optional Dependent Term Life, Optional Accidental Death & Dismemberment, and Short Term Disability

Issued by The Prudential Insurance Company of America

This is a summary of benefits and does not include all plan provisions, exclusions and limitations. If there is a discrepancy between this document and the group contract issued by The Prudential Insurance Company of America, the terms of the group contract will govern.

Basic Term Life

100% Employer Paid	▶ Basic Term Life - You are automatically enrolled for $40,000. **Please refer to your plan certificate(s) to review the required minimum and maximum coverage amounts allowed.** ▶ If you are terminally ill, you can get a partial payment of your group life insurance benefit. You can use this payment as you see fit. The payment to your beneficiary will be reduced by the amount you receive with the Accelerated Benefit Option.* Refer to the plan booklet for details ▶ Payment of premium can be waived if you are totally disabled for 9 months, you are less than 60 years old when the disability begins, and you continue to be totally disabled. This waiver terminates at age 65. This provision may vary by state. ▶ Coverage will be reduced as you age – by 35% at age 65 and 50% at age 70. ▶ You may convert your insurance to an individual life insurance policy issued by the Prudential Insurance Company of America.

Basic Accidental Death & Dismemberment

100% Employer Paid	▶ Basic Accidental Death & Dismemberment pays you and your beneficiary a benefit for the loss of life or other injuries resulting from a covered accident — 100% for loss of life and a lesser percentage for other injuries. Injuries covered may include loss of sight or speech, paralysis, and dismemberment of hands or feet. Basic Accidental Death & Dismemberment benefits are paid regardless of other coverages you may have. ▶ Basic Accidental Death & Dismemberment: You are automatically enrolled for an amount equal to your Basic Term Life coverage amount. ▶ Coverage will be reduced as you age – by 35% at age 65 and 50% at age 70.

Employee - Optional Term Life

100% Employee Paid	▶ Purchase coverage in increments of $10,000 up to a maximum of $500,000, not to exceed 5 times your covered annual earnings. **Please refer to your plan certificate(s) to review the required minimum and maximum coverage amounts allowed.** – If enrolling when first eligible, you can elect up to the guaranteed issue amount of $100,000 without providing proof of good health to Prudential. [1] – You may be eligible to increase your coverage amount annually in increments of $10,000 not to exceed an increase of 5 times your covered annual earnings, to a total coverage amount of the Guaranteed Issue amount, without satisfying evidence of insurability. [1] ▶ If terminally ill, you can get a partial payment of your group term life insurance benefit. You can use this payment as you see fit. In the event of your death, your beneficiary will receive a benefit payout which has been reduced by the amount you receive. ▶ Payment of premium can be waived if you are totally disabled for 9 months, you are less than 60 years old when the disability begins, and you continue to be totally disabled. This waiver terminates at age 65. This provision may vary by state. ▶ Coverage will be reduced as you age – by 35% at age 65 and 50% at age 70. ▶ You may convert your insurance to an individual life insurance policy issued by the Prudential Insurance Company of America, or you may be eligible to port your coverage ending to a separate group term life contract.

Spouse - Optional Dependent Term Life

100% Employee Paid	▶ Purchase coverage on your spouse in increments of $5,000 up to a maximum of $100,000. **Please Note:** The Optional Dependent Term Life coverage amount on your spouse cannot exceed 50% of your Optional Term Life coverage amount. – If enrolling your spouse when first eligible, you can elect up to the guaranteed issue amount of $25,000, on your spouse, without providing proof of good health to Prudential. [1] ▶ Coverage will be reduced as you age – by 35% at age 65 and 50% at age 70. ▶ You may convert your dependent(s) insurance to an individual life insurance policy issued by the Prudential Insurance Company of America, or you may be eligible to port your dependent(s) coverage ending to a separate group term life contract.

Child - Optional Dependent Term Life

100% Employee Paid	▶ Purchase coverage on your child in increments of $1,000 up to a maximum of $10,000. **Please note:** The Optional Dependent Term Life Insurance coverage amount on your children may not exceed 50% of your Optional Term Life coverage amount. ▶ Coverage begins from 14 days, and continues to age 19, if unmarried. If unmarried, dependent on you and a full-time student, coverage continues to age 25. ▶ You may convert your dependent(s) insurance to an individual life insurance policy issued by the Prudential Insurance Company of America, or you may be eligible to port your dependent(s) coverage ending to a separate group term life contract.

Employee - Optional Accidental Death & Dismemberment

100% Employee Paid	▶ Purchase a coverage amount equal to your Optional Term Life coverage amount. ▶ Coverage will be reduced as you age – by 35% at age 65 and 50% at age 70.

Spouse - Optional Accidental Death & Dismemberment

100% Employee Paid	▶ Purchase an Optional Accidental Death & Dismemberment Insurance coverage amount for your spouse equal to your spouse Optional Dependent Term Life Insurance coverage amount. ▶ Coverage will be reduced as you age – by 35% at age 65 and 50% at age 70.

Child - Optional Accidental Death & Dismemberment

100% Employee Paid	▶ Purchase an Optional Accidental Death & Dismemberment Insurance coverage amount on your child(ren) equal to your child(ren) Optional Dependent Term Life Insurance coverage amount. ▶ Coverage begins at live birth, and continues to age 19, if unmarried. If unmarried, dependent on you and a full-time student, coverage continues to age 25.

Short Term Disability

100% Employee Paid	▶ Your weekly Short Term Disability benefit will be 60% of your weekly pre-disability earnings, up to the maximum of $1,000, less deductible sources of income. No medical questions asked - if enrolling when first eligible. The minimum weekly benefit is $50. ▶ Deductible sources of income may include benefits from statutory plans, unemployment income and salary continuation. ▶ If you meet the definition of disability, your benefits will begin on the 15th day following a non-occupational injury or the 15th day following a non-occupational sickness. The benefit duration is 26 weeks. You are considered disabled when, because of injury or sickness, you are under the regular care of the doctor, are unable to perform the material and substantial duties of your regular occupation and your disability results in a loss of weekly income of at least 20%. ▶ STD benefits will not be paid for a disability that begins within 12 months of your coverage effective date and is due to a pre-existing condition. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, diagnostic measures, prescribed drugs or medicines, or for which you followed treatment recommendations during the 3 months prior to your effective date of coverage. ▶ You are not covered for a disability caused by war or any act of war, declared or undeclared, an intentionally self-inflicted injury, active participation in a riot, and commission of a crime for which you have been convicted. Benefits are not payable for any period of incarceration as a result of a conviction.

Rate Sheet

Riverside School District #2

All Employees

Issued by The Prudential Insurance Company of America (Prudential)

Effective: 07/01/2023

Employee Optional Term Life Monthly cost per coverage amount

Coverage is available in increments of $10,000 to a maximum of $500,000, not to exceed 5 times your covered annual earnings. Refer to the Optional Term Life section for evidence of insurability details. Initial rates based on age as of effective date of your coverage. Rates will change based on the following age schedule.

	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000	$120,000
Age												
Under 25	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50	$3.85	$4.20
25 to 29	$0.42	$0.84	$1.26	$1.68	$2.10	$2.52	$2.94	$3.36	$3.78	$4.20	$4.62	$5.04
30 to 34	$0.56	$1.12	$1.68	$2.24	$2.80	$3.36	$3.92	$4.48	$5.04	$5.60	$6.16	$6.72
35 to 39	$0.63	$1.26	$1.89	$2.52	$3.15	$3.78	$4.41	$5.04	$5.67	$6.30	$6.93	$7.56
40 to 44	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$4.90	$5.60	$6.30	$7.00	$7.70	$8.40
45 to 49	$1.05	$2.10	$3.15	$4.20	$5.25	$6.30	$7.35	$8.40	$9.45	$10.50	$11.55	$12.60
50 to 54	$1.62	$3.24	$4.86	$6.48	$8.10	$9.72	$11.34	$12.96	$14.58	$16.20	$17.82	$19.44
55 to 59	$3.02	$6.04	$9.06	$12.08	$15.10	$18.12	$21.14	$24.16	$27.18	$30.20	$33.22	$36.24
60 to 64	$4.64	$9.28	$13.92	$18.56	$23.20	$27.84	$32.48	$37.12	$41.76	$46.40	$51.04	$55.68
65 to 69	$8.92	$17.84	$26.76	$35.68	$44.60	$53.52	$62.44	$71.36	$80.28	$89.20	$98.12	$107.04
70 to 100	$14.47	$28.94	$43.41	$57.88	$72.35	$86.82	$101.29	$115.76	$130.23	$144.70	$159.17	$173.64

Age	$130,000	$140,000	$150,000	$160,000	$170,000	$180,000	$190,000	$200,000	$210,000	$220,000	$230,000	$240,000
Under 25	$4.55	$4.90	$5.25	$5.60	$5.95	$6.30	$6.65	$7.00	$7.35	$7.70	$8.05	$8.40
25 to 29	$5.46	$5.88	$6.30	$6.72	$7.14	$7.56	$7.98	$8.40	$8.82	$9.24	$9.66	$10.08
30 to 34	$7.28	$7.84	$8.40	$8.96	$9.52	$10.08	$10.64	$11.20	$11.76	$12.32	$12.88	$13.44
35 to 39	$8.19	$8.82	$9.45	$10.08	$10.71	$11.34	$11.97	$12.60	$13.23	$13.86	$14.49	$15.12
40 to 44	$9.10	$9.80	$10.50	$11.20	$11.90	$12.60	$13.30	$14.00	$14.70	$15.40	$16.10	$16.80
45 to 49	$13.65	$14.70	$15.75	$16.80	$17.85	$18.90	$19.95	$21.00	$22.05	$23.10	$24.15	$25.20
50 to 54	$21.06	$22.68	$24.30	$25.92	$27.54	$29.16	$30.78	$32.40	$34.02	$35.64	$37.26	$38.88
55 to 59	$39.26	$42.28	$45.30	$48.32	$51.34	$54.36	$57.38	$60.40	$63.42	$66.44	$69.46	$72.48
60 to 64	$60.32	$64.96	$69.60	$74.24	$78.88	$83.52	$88.16	$92.80	$97.44	$102.08	$106.72	$111.36
65 to 69	$115.96	$124.88	$133.80	$142.72	$151.64	$160.56	$169.48	$178.40	$187.32	$196.24	$205.16	$214.08
70 to 100	$188.11	$202.58	$217.05	$231.52	$245.99	$260.46	$274.93	$289.40	$303.87	$318.34	$332.81	$347.28

Age	$250,000	$260,000	$270,000	$280,000	$290,000	$300,000	$310,000	$320,000	$330,000	$340,000	$350,000	$360,000
Under 25	$8.75	$9.10	$9.45	$9.80	$10.15	$10.50	$10.85	$11.20	$11.55	$11.90	$12.25	$12.60
25 to 29	$10.50	$10.92	$11.34	$11.76	$12.18	$12.60	$13.02	$13.44	$13.86	$14.28	$14.70	$15.12
30 to 34	$14.00	$14.56	$15.12	$15.68	$16.24	$16.80	$17.36	$17.92	$18.48	$19.04	$19.60	$20.16
35 to 39	$15.75	$16.38	$17.01	$17.64	$18.27	$18.90	$19.53	$20.16	$20.79	$21.42	$22.05	$22.68
40 to 44	$17.50	$18.20	$18.90	$19.60	$20.30	$21.00	$21.70	$22.40	$23.10	$23.80	$24.50	$25.20
45 to 49	$26.25	$27.30	$28.35	$29.40	$30.45	$31.50	$32.55	$33.60	$34.65	$35.70	$36.75	$37.80
50 to 54	$40.50	$42.12	$43.74	$45.36	$46.98	$48.60	$50.22	$51.84	$53.46	$55.08	$56.70	$58.32
55 to 59	$75.50	$78.52	$81.54	$84.56	$87.58	$90.60	$93.62	$96.64	$99.66	$102.68	$105.70	$108.72
60 to 64	$116.00	$120.64	$125.28	$129.92	$134.56	$139.20	$143.84	$148.48	$153.12	$157.76	$162.40	$167.04
65 to 69	$223.00	$231.92	$240.84	$249.76	$258.68	$267.60	$276.52	$285.44	$294.36	$303.28	$312.20	$321.12
70 to 100	$361.75	$376.22	$390.69	$405.16	$419.63	$434.10	$448.57	$463.04	$477.51	$491.98	$506.45	$520.92

Age	$370,000	$380,000	$390,000	$400,000	$410,000	$420,000	$430,000	$440,000	$450,000	$460,000	$470,000	$480,000
Under 25	$12.95	$13.30	$13.65	$14.00	$14.35	$14.70	$15.05	$15.40	$15.75	$16.10	$16.45	$16.80
25 to 29	$15.54	$15.96	$16.38	$16.80	$17.22	$17.64	$18.06	$18.48	$18.90	$19.32	$19.74	$20.16
30 to 34	$20.72	$21.28	$21.84	$22.40	$22.96	$23.52	$24.08	$24.64	$25.20	$25.76	$26.32	$26.88
35 to 39	$23.31	$23.94	$24.57	$25.20	$25.83	$26.46	$27.09	$27.72	$28.35	$28.98	$29.61	$30.24
40 to 44	$25.90	$26.60	$27.30	$28.00	$28.70	$29.40	$30.10	$30.80	$31.50	$32.20	$32.90	$33.60
45 to 49	$38.85	$39.90	$40.95	$42.00	$43.05	$44.10	$45.15	$46.20	$47.25	$48.30	$49.35	$50.40
50 to 54	$59.94	$61.56	$63.18	$64.80	$66.42	$68.04	$69.66	$71.28	$72.90	$74.52	$76.14	$77.76
55 to 59	$111.74	$114.76	$117.78	$120.80	$123.82	$126.84	$129.86	$132.88	$135.90	$138.92	$141.94	$144.96
60 to 64	$171.68	$176.32	$180.96	$185.60	$190.24	$194.88	$199.52	$204.16	$208.80	$213.44	$218.08	$222.72
65 to 69	$330.04	$338.96	$347.88	$356.80	$365.72	$374.64	$383.56	$392.48	$401.40	$410.32	$419.24	$428.16
70 to 100	$535.39	$549.86	$564.33	$578.80	$593.27	$607.74	$622.21	$636.68	$651.15	$665.62	$680.09	$694.56

	$490,000	$500,000
Age		
Under 25	$17.15	$17.50
25 to 29	$20.58	$21.00
30 to 34	$27.44	$28.00
35 to 39	$30.87	$31.50
40 to 44	$34.30	$35.00
45 to 49	$51.45	$52.50
50 to 54	$79.38	$81.00
55 to 59	$147.98	$151.00
60 to 64	$227.36	$232.00
65 to 69	$437.08	$446.00
70 to 100	$709.03	$723.50

Rates may change as the insured enters a higher age category. Also, rates may change if plan experience requires a change for all insureds.

Spouse - Optional Dependent Term Life Monthly cost per coverage amount

Coverage is available on your spouse in increments of $5,000 to a maximum of $100,000. **Please Note:** The Optional Dependent Term Life coverage amount on your spouse cannot exceed 50% of your Optional Term Life coverage amount. Refer to the Optional Dependent Term Life section for evidence of insurability details. Initial rates based on age as of effective date of your coverage. Rates will change based on the following age schedule.

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000	$55,000	$60,000
Age												
Under 20	$0.19	$0.38	$0.57	$0.76	$0.95	$1.14	$1.33	$1.52	$1.71	$1.90	$2.09	$2.28
20 to 24	$0.23	$0.45	$0.68	$0.90	$1.13	$1.35	$1.58	$1.80	$2.03	$2.25	$2.48	$2.70
25 to 29	$0.25	$0.50	$0.75	$1.00	$1.25	$1.50	$1.75	$2.00	$2.25	$2.50	$2.75	$3.00
30 to 34	$0.28	$0.56	$0.84	$1.12	$1.40	$1.68	$1.96	$2.24	$2.52	$2.80	$3.08	$3.36
35 to 39	$0.36	$0.71	$1.07	$1.42	$1.78	$2.13	$2.49	$2.84	$3.20	$3.55	$3.91	$4.26
40 to 44	$0.46	$0.92	$1.38	$1.84	$2.30	$2.76	$3.22	$3.68	$4.14	$4.60	$5.06	$5.52
45 to 49	$0.68	$1.36	$2.04	$2.72	$3.40	$4.08	$4.76	$5.44	$6.12	$6.80	$7.48	$8.16
50 to 54	$1.07	$2.14	$3.21	$4.28	$5.35	$6.42	$7.49	$8.56	$9.63	$10.70	$11.77	$12.84
55 to 59	$1.77	$3.53	$5.30	$7.06	$8.83	$10.59	$12.36	$14.12	$15.89	$17.65	$19.42	$21.18
60 to 64	$3.22	$6.43	$9.65	$12.86	$16.08	$19.29	$22.51	$25.72	$28.94	$32.15	$35.37	$38.58
65 to 69	$5.44	$10.88	$16.32	$21.76	$27.20	$32.64	$38.08	$43.52	$48.96	$54.40	$59.84	$65.28
70 to 74	$9.54	$19.08	$28.62	$38.16	$47.70	$57.24	$66.78	$76.32	$85.86	$95.40	$104.94	$114.48
75 to 79	$16.15	$32.30	$48.45	$64.60	$80.75	$96.90	$113.05	$129.20	$145.35	$161.50	$177.65	$193.80
80 to 84	$28.23	$56.46	$84.69	$112.92	$141.15	$169.38	$197.61	$225.84	$254.07	$282.30	$310.53	$338.76
85 to 100	$125.50	$250.99	$376.49	$501.98	$627.48	$752.97	$878.47	$1,003.96	$1,129.46	$1,254.95	$1,380.45	$1,505.94

Age	$65,000	$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000				
Under 20	$2.47	$2.66	$2.85	$3.04	$3.23	$3.42	$3.61	$3.80				
20 to 24	$2.93	$3.15	$3.38	$3.60	$3.83	$4.05	$4.28	$4.50				
25 to 29	$3.25	$3.50	$3.75	$4.00	$4.25	$4.50	$4.75	$5.00				
30 to 34	$3.64	$3.92	$4.20	$4.48	$4.76	$5.04	$5.32	$5.60				
35 to 39	$4.62	$4.97	$5.33	$5.68	$6.04	$6.39	$6.75	$7.10				
40 to 44	$5.98	$6.44	$6.90	$7.36	$7.82	$8.28	$8.74	$9.20				
45 to 49	$8.84	$9.52	$10.20	$10.88	$11.56	$12.24	$12.92	$13.60				
50 to 54	$13.91	$14.98	$16.05	$17.12	$18.19	$19.26	$20.33	$21.40				
55 to 59	$22.95	$24.71	$26.48	$28.24	$30.01	$31.77	$33.54	$35.30				
60 to 64	$41.80	$45.01	$48.23	$51.44	$54.66	$57.87	$61.09	$64.30				
65 to 69	$70.72	$76.16	$81.60	$87.04	$92.48	$97.92	$103.36	$108.80				
70 to 74	$124.02	$133.56	$143.10	$152.64	$162.18	$171.72	$181.26	$190.80				
75 to 79	$209.95	$226.10	$242.25	$258.40	$274.55	$290.70	$306.85	$323.00				
80 to 84	$366.99	$395.22	$423.45	$451.68	$479.91	$508.14	$536.37	$564.60				
85 to 100	$1,631.44	$1,756.93	$1,882.43	$2,007.92	$2,133.42	$2,258.91	$2,384.41	$2,509.90				

Rates may change as the insured enters a higher age category. Also, rates may change if plan experience requires a change for all insureds. Spouse rate is based on Employee's age.

Children - Optional Dependent Term Life Monthly cost per coverage amount

One premium rate covers all eligible children

Coverage is available on your children in increments of $1,000, not to exceed a maximum of $10,000. **Please note:** The Optional Dependent Term Life Insurance coverage amount on your children may not exceed 50% of your Optional Term Life coverage amount.

$1,000	$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$8,000	$9,000	$10,000
$0.09	$0.17	$0.26	$0.35	$0.44	$0.52	$0.61	$0.70	$0.78	$0.87

Rates may change if plan experience requires a change for all insureds.

Employee Optional Accidental Death & Dismemberment Monthly cost per coverage amount

Purchase an Optional Accidental Death & Dismemberment coverage amount equal to your Optional Term Life coverage amount. Refer to the Optional Accidental Death & Dismemberment section for evidence of insurability details.

$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000	$120,000	$130,000
$0.15	$0.30	$0.45	$0.60	$0.75	$0.90	$1.05	$1.20	$1.35	$1.50	$1.65	$1.80	$1.95

$140,000	$150,000	$160,000	$170,000	$180,000	$190,000	$200,000	$210,000	$220,000	$230,000	$240,000	$250,000	$260,000
$2.10	$2.25	$2.40	$2.55	$2.70	$2.85	$3.00	$3.15	$3.30	$3.45	$3.60	$3.75	$3.90

$270,000	$280,000	$290,000	$300,000	$310,000	$320,000	$330,000	$340,000	$350,000	$360,000	$370,000	$380,000	$390,000
$4.05	$4.20	$4.35	$4.50	$4.65	$4.80	$4.95	$5.10	$5.25	$5.40	$5.55	$5.70	$5.85

$400,000	$410,000	$420,000	$430,000	$440,000	$450,000	$460,000	$470,000	$480,000	$490,000	$500,000		
$6.00	$6.15	$6.30	$6.45	$6.60	$6.75	$6.90	$7.05	$7.20	$7.35	$7.50		

Spouse Optional Accidental Death & Dismemberment Monthly cost per coverage amount

Purchase an Optional Accidental Death & Dismemberment coverage amount equal to your Optional Dependent Term Life coverage amount. Refer to the Optional Accidental Death & Dismemberment section for evidence of insurability details.

$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000	$55,000	$60,000	$65,000
$0.10	$0.20	$0.30	$0.40	$0.50	$0.60	$0.70	$0.80	$0.90	$1.00	$1.10	$1.20	$1.30

$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000					
$1.40	$1.50	$1.60	$1.70	$1.80	$1.90	$2.00					

Children Optional Accidental Death & Dismemberment Monthly cost per coverage amount

One premium rate covers all eligible children

Purchase an Optional Accidental Death & Dismemberment coverage amount equal to your Child Optional Dependent Term Life coverage amount.

$1,000	$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$8,000	$9,000	$10,000
$0.01	$0.02	$0.03	$0.04	$0.05	$0.06	$0.07	$0.08	$0.09	$0.10

Cost of Short Term Disability

Use the chart below to find the cost of Short Term Disability insurance. Follow the steps below to calculate your coverage cost. Your maximum weekly benefit amount is $1,000. Your coverage level is limited to the salary of $86,667.

Employee's Age	Employee's Rate
Under 20	$0.305
20-24	$0.368
25-29	$0.641
30-34	$0.851
35-39	$0.641
40-44	$0.42
45-49	$0.515
50-54	$0.609
55-59	$0.777
60-64	$0.945
65-69	$1.166
70-100	$1.449

Rates may change as the insured enters a higher age category. Also, rates may change if plan experience requires a change for all insureds.

How to calculate your total STD Monthly cost

Step 1	Indicate your weekly earnings.	=$
Step 2	Multiply your weekly earnings by 60%	=$
Step 3	If the amount in Step 2 is greater than $1,000, indicate $1,000. Otherwise, indicate the amount from Step 2.	=$
Step 4	Multiply the amount in Step 3 by the rate for your age and divide by 10 to obtain your total STD monthly cost.	=$

403(b) & 457

RETIREMENT

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION 2023

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN

The 403(b) and 457(b) Plans are valuable retirement savings options. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) and 457(b) Plans offered.

Plan administration services for the 403(b) and 457(b) plans are provided by U.S. OMNI & TSACG Compliance Services. Visit the U.S. OMNI & TSACG Compliance Services' website *(https://www.tsacg.com)* for information about enrollment in the plan, investment product providers available, distributions, exchanges or transfers, 403(b) and/or 457(b) loans, and rollovers.

ELIGIBILITY

Most employees are eligible to participate in the 403(b) and 457(b) plans immediately upon employment; however, private contractors, appointed/elected trustees and/or school board members are not eligible to participate in the 403(b) plan. Please verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans. Participants are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) and/or 457(b) account(s) up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) or 457(b) accounts are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. U.S. OMNI & TSACG Compliance Services monitors 403(b) and 457(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2023 IS $22,500.
Additional provisions allowed:

AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $7,500 to the 403(b) and/or 457(b) accounts.

THE SERVICE-BASED CATCH UP AMOUNT

The 403(b) special catch-up provision allows participants to make additional contributions of up to $3,000 to the 403(b) account if, as of the preceding calendar year, the participant has completed 15 or more full years of employment with the current employer, not averaged over $5,000 per year in annual contributions, and has not utilized catch-up contributions in excess of the aggregate of $15,000. For a detailed explanation of this provision, please visit *https://www.tsacg.com.*

ENROLLMENT

Employees who wish to enroll in the 403(b) and/or 457(b) plan must first select the provider and investment product best suited for their account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and/or a deferred compensation enrollment form and any disclosure forms must be completed and submitted to the employer. These forms authorize the employer to withhold 403(b) and/or 457(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. A SRA form and/or a deferred compensation enrollment form must be completed to start, stop or modify contributions to 403(b) and/or 457(b) accounts. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Please note: The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.

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INVESTMENT PROVIDER INFORMATION

A current list of authorized 403(b) and 457(b) Investment Providers and current employer forms are available on the employer's specific Web page at *https://www.tsacg.com.*

PLAN DISTRIBUTION TRANSACTIONS

Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, unforeseen financial emergency withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing.

PLAN-TO-PLAN TRANSFERS

A plan-to-plan transfer is defined as the movement of a 403(b) and/or 457(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

ROLLOVERS

Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS

Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations unless they have attained age 59½ or separated from service in the year in which they turn 55 or older. Generally, a distribution cannot be made from a 457(b) account until you have reach age 59½ or have a severance from employment. In most cases, any withdrawals made from a 403(b) or 457(b) account are taxable in full as ordinary income.

EXCHANGES

Within each plan, participants may exchange account accumulations from one investment provider to another investment provider that is authorized under the same plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange. Exchanges can only be made from one 457(b) plan to another 457(b) plan, or from one 403(b) plan to another 403(b) plan.

403(b) and 457(b) PLAN LOANS

Participants may be eligible to borrow their 403(b) and/or 457(b) plan accumulations depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider. Prior to taking a loan, participants should consult a tax advisor.

HARDSHIP WITHDRAWALS

Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must verify and provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at *https://www.tsacg.com.*

UNFORESEEN FINANCIAL EMERGENCY WITHDRAWAL

You may be able to take a withdrawal from your 457(b) account in the event of an unforeseen financial emergency. An unforeseeable emergency is defined as a severe financial hardship of the participant or beneficiary. The eligibility requirements to receive a Unforeseen Financial Emergency Withdrawal are provided on the Unforeseen Financial Emergency Withdrawal Disclosure form at *https://www.tsacg.com.*

EMPLOYEE INFORMATION STATEMENT

Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) and 457(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

PLAN ADMINISTRATOR CONTACT INFORMATION

Transactions
P.O. Box 4037
Fort Walton Beach, FL 32549
Toll-free: 1-888-796-3786
https://www.tsacg.com

For overnight deliveries
73 Eglin Parkway NE, Suite 202
Fort Walton Beach, FL 32548
Toll-free: 1-888-796-3786
https://www.tsacg.com

Plan Participation Guide

It's your future. Own it.

Plan Participation Guide

What you will find in your Plan Participation Guide

Meet Our Team. 2

Getting Started. 3

- Understanding your Plan
- Why Contribute?
- Online Resources
- Submitting Distributions
- Submitting SRAs

Enrollment. 4

Dear Employee,

Our goal at U.S. OMNI & TSACG Compliance Services is to make your life easier by ensuring your employer's supplemental retirement plan is administered properly and by ensuring that you have the resources you need to take full advantage of the opportunity to participate.

Your employer has placed the administration of their plan(s) in our hands, and this is not a responsibility we take lightly. It is our promise to you that no matter where you are at in life - actively working, nearing retirement, or retired - we will dedicate the time and effort to simplify how you access your account and manage your contributions.

This Plan Participation Guide was developed to provide resource information, but as you dive deeper into the management of your retirement accounts, you may find that you still have questions. Don't worry. We are here to help. Our Customer Service Representatives are available to assist with distribution submission and approval questions as well as salary reduction agreement submission questions. The contact information for our teams can be found later in this document.

Welcome to your benefits plan. We are happy you are here.

Sincerely,
U.S. OMNI & TSACG Compliance Services

Meet U.S. OMNI & TSACG Compliance Services

Making sure you receive the financial wellness resources you deserve.

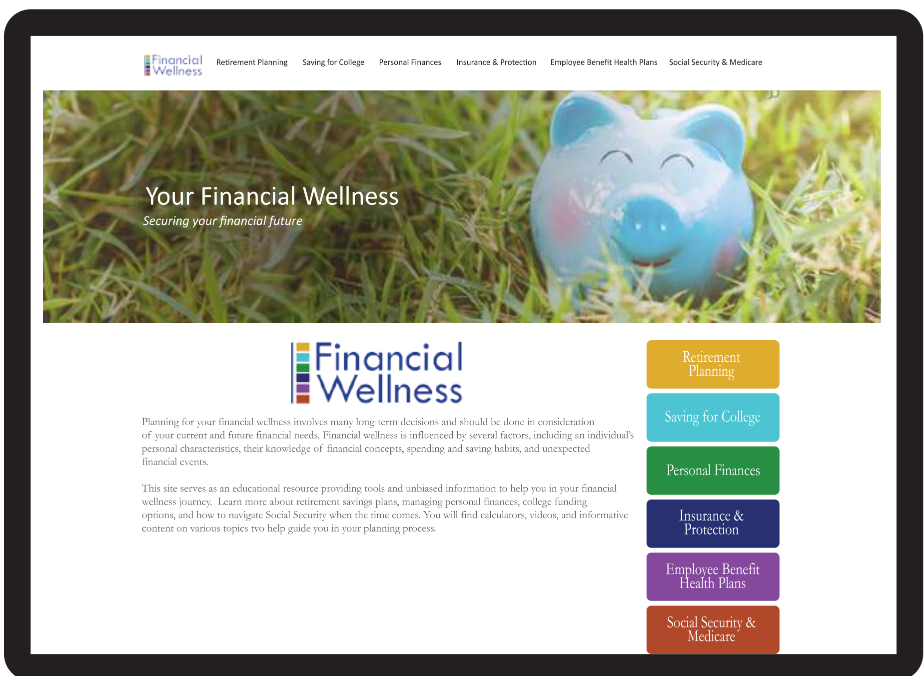
At our core, we are a group of people helping people achieve their retirement planning and wellness goals. We are just like you. We work hard so that one day we, too, can have a secure financial future.

We understand that financial preparedness should be stress-free, so we are here to make sure your plan is administered properly. We take care of the administrative details of your plan, such as remitting contributions, authorizing distribution requests, and answering everyday questions.

Since 1996, we have grown dramatically while remaining focused on what truly matters most: people. Whether it is you, your employer, our employees, or our community, we focus on connecting people with financial wellness solutions that lead to a more fulfilled life.

Many of these solutions can be found in our Financial Wellness Center. The center program contains planning modules that allow you to watch, read, or plan utilizing numerous planning calculators, videos, and educational articles. Center resources can be accessed 24/7.

Financial Wellness Center: https://usrbpfinancialwellness.com/



Getting Started

An introduction to your plan.

Understanding Your Plan

A 403(b) or 457(b) plan allows you to save for retirement on a tax-deferred basis. Your contributions are voluntary, and you can choose the amount based on your retirement goals. For more specific information on your employer's plan design, please reference the Meaningful Notice, which can be accessed by searching for your employer forms and information at https://www.tsacg.com/individual/plan-sponsor/.

Why Wait?

Simply put, waiting could cost you. You might ask: What difference could ten years make? Let's say you wanted to build a $500,000 nest egg to help bridge the gap of your current retirement savings plan. If you start at age 25, you will need to contribute at least $1,500 annually to a plan earning 10% in order to meet your goal; however, if you were to wait ten years to start, you will need to contribute at least $4,400 annually to earn the same amount. The earlier you start, the more potential earnings you can enjoy later in life.

Online Resources

Once enrolled in the plan, you have 24/7 access to a variety of educational tools and plan resources online. Available in the FORMS or INDIVIDUAL sections at https://www.tsacg.com, your online access allows you to obtain plan forms, access guides and videos on how to use the website, view the plan's authorized investment providers, and so much more.

Submitting Distributions

Within just a few minutes, distribution requests can be submitted and approved using our Online Distribution System. This online system allows participants and advisors alike to gain immediate approval certification for eligible distributions. Further, all distribution requests may be submitted in this manner -- even those that require supporting documentation. U.S. OMNI & TSACG Compliance Services' Online Distribution System can be found on the homepage at https://www.tsacg.com, and is available 24/7. For more information on submitting distributions, please visit our website.

Submitting Salary Reduction Agreements

If this service is being utilized by your employer, you also have the ability to start, change, or stop a deduction at your convenience via our online Salary Reduction Agreement system. This system, which is available 24/7, will provide an immediate confirmation when the request has been submitted. The system also permits your financial advisor/representative to assist you in this process. Your employer's page on https://www.tsacg.com houses both a link to the online system and step-by-step instructions.

Enrollment

You have decided to participate in the plan. Now what?

After reviewing your employer's 403(b) or 457(b) plan, you will likely want to take advantage of saving for retirement on a tax-deferred basis. Here are some tips on how to get started.

Pick Your Investment Provider

You will want to review your employer's list of authorized investment providers and determine where you want to invest your money. A complete list of your investment providers is available to you when you visit your employer's page on https://www.tsacg.com/individual/plan-sponsor/. Not sure which investment provider to choose? Review company marketing materials, consult with your financial advisor, or ask a trusted colleague or mentor if they work with an advisor or investment provider they would recommend.

Contact Your Chosen Investment Provider

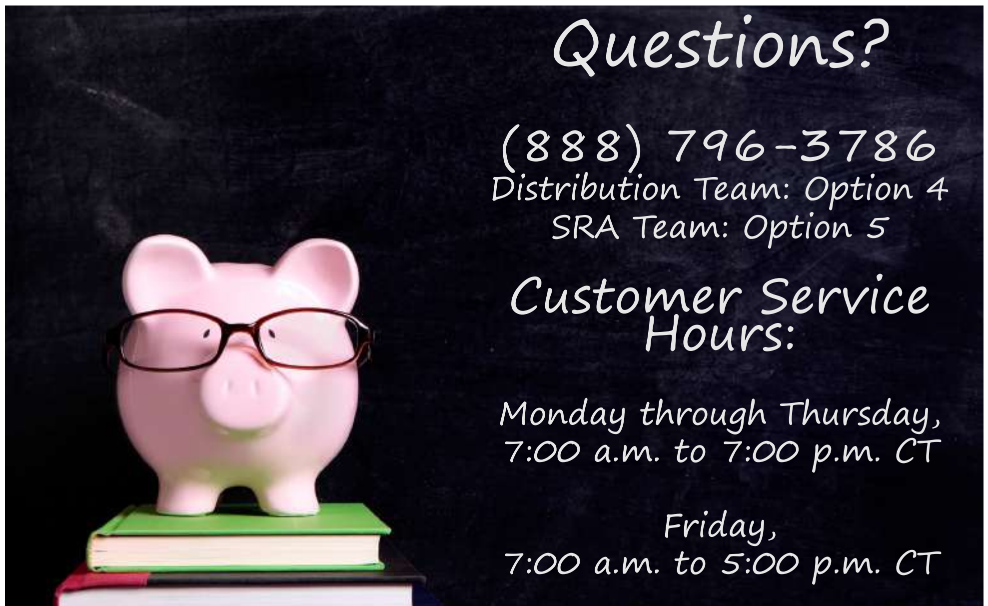
Once you have decided on an investment provider or providers, be sure to contact them and establish an account.

Complete a Salary Reduction Agreement

Next, you simply complete a Salary Reduction Agreement (SRA) via the process defined by your employer. Your employer's page at https://www.tsacg.com/individual/plan-sponsor/ will either reflect the instructions to submit an SRA via U.S. OMNI & TSACG Compliance Services' online SRA system, and/or house an SRA which can be completed and submitted via the instructions provided by your employer.

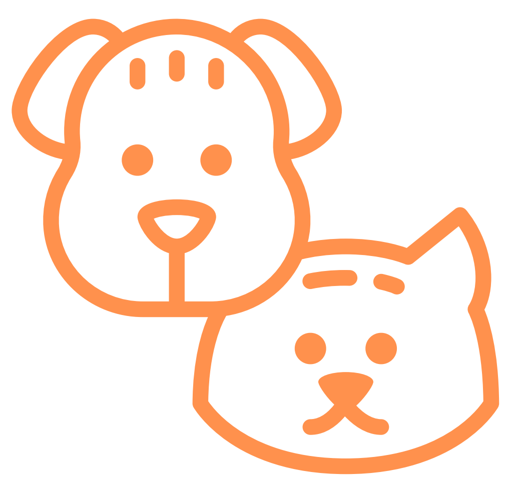
What Happens Next?

Once you have submitted your SRA request, your employer will begin deducting your contribution amount from your paycheck and send the funds to your chosen investment provider or providers.



Pet

INSURANCE



DOGS | CATS | RABBITS | BIRDS | REPTILES | POCKET PETS

Got a pet?

Save at the vet!

Riverside Elementary School District No. 2

wants to remind you of this fantastic employee benefit!

Better than insurance!

Join regardless of pet's age or medical conditions

Extremely affordable at only $12.50 / month or less

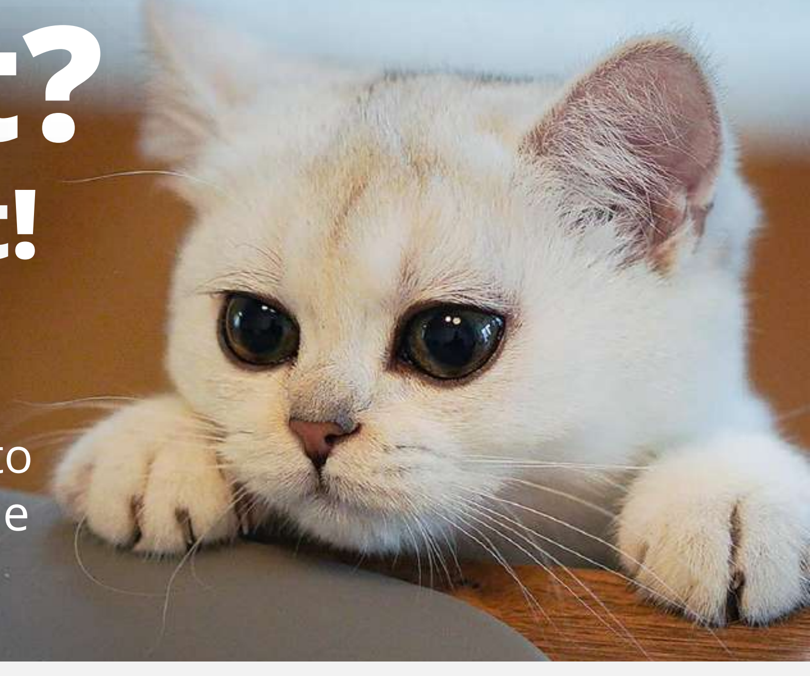
INSTANT savings of 20-50% on every visit

No deductibles or claim forms

For more information, or to enroll:
(949) 916-7374 CA
(602) 266-5303 AZ

www.unitedpetcare.com/riverside

DOGS | CATS | RABBITS | BIRDS | REPTILES | POCKET PETS



Got a pet?

Save at the vet!

Riverside Elementary School District No. 2 is pleased to offer our employees the opportunity to save on your veterinary care. One low price includes preventative, accident, and sick care.

Employees receive INSTANT savings of 20-50% off every veterinary visit!

United Pet Care features NO claim forms, NO deductibles, NO waiting period, NO age exclusions and NO exclusions due to pre-existing or breed-specific conditions.

Veterinary Service	Estimated Cost*	UPC Member Savings
Routine Wellness Exam	$80	Save $20.00
Vaccinations	$120	Save $30.00
Fecal Exam	$57	Save $14.25
Spay / Neuter	$250	Save $62.50
In-House Lab Work	$96	Save $24.00
Dental Cleaning & X-Rays	$475	Save $118.75
Emergency Visit Fee	$90	Save $45.00
X-Rays	$120	Save $30.00
Cruciate Ligament Repair	$825	Save $206.25
Tumor Removal	$525	Save $131.25

* Discounts are taken at your in-network veterinary office at time of service

For more information, or to enroll:
(949) 916-7374 CA
(602) 266-5303 AZ

www.unitedpetcare.com
Complete enrollment through your Human Resources process

Our Preferred Savings Program

$AVE 25%-50%* ON SERVICES INCLUDING:

- OFFICE VISITS
- ANNUAL EXAMS
- ANNUAL VACCINES

$AVE 20%-25% ON SERVICES INCLUDING:

- PROCEDURES
- MEDICATIONS
- Dental Cleaning
- Spay & Neuter

...and so much more!

**Savings varies by vet. Please visit our wensite to see the amount of savings offered by the vets in your area

Making pet healthcare easy and affordable!

Become a United Pet Care member and start saving now

Enroll Today !

FOR MORE INFORMATION ON OUR PROGRAM,BENEFITS, OR TO SEE OUR PARTICIPATING VETS PLEASE VISIT: UNITEDPETCARE.COM

A Healthy Pet is a Happy Pet.

Save 20%-50% on every vet visit!

About United Pet Care

Don't miss out on all the ways to save like thousands of other pet parents!

United Pet Care is a pet healthcare program built to make high-quality care accessible and affordable to pet parents everywhere.

Get the veterinary care your fur babies deserve and save 20%-50% with United Pet Care!

Better than Pet Insurance!

ALL PETS ARE ELIGIBLE

No Exclusions.

due to pre-existing conditions, age, or breed-specific conditions

No Deductibles.

save at any cost with no cap on annual savings

No Claim Forms.

savings are given **INSTANTLY** at the veterinarian office

UNITEDPETCARE.COM

UNITED PET CARE

Contact Us Today!

Info@UnitedPetCare.com

877-872-8800

UnitedPetCare.Com

@UnitedPetCare

whiskerDocs

NEW 24/7 Pet Helpline for UPC Members

What is whiskerDocs?

An enterprise level pet helpline for United Pet Care members! whiskerDocs is the perfect blend of technology and expertise to assist pet owners in the everyday health and care of their pets. whiskerDocs will automatically be included in all members' UPC portals upon renewal.

What's included:

- Available 24/7, anywhere
- Little to no wait time
- Veterinary experts who provide real-time decision support
- 99% satisfaction rate
- Call, chat and email features
- Call records sent directly to your Primary Care Vet

Additional

BENEFITS

Welcome to the Arizona State Retirement System!

As a new employee with Riverside Elementary School District # 2 it is important you take a few minutes to complete your online registration with the Arizona State Retirement System. It's quick, easy and secure.

1: Click on this link* and go through the entire process as directed in the application:
https://secure.azasrs.gov/web/MemberRegistrationWizard.do

*Or you can go to www.azasrs.gov click "myASRS Login" then click "First Time Registering?"

2: To use this application, you will first be asked to **agree to the Access Agreement.** Read through and click 'I agree' when ready to proceed.

3: Enter your enrollment code:

2XV00046

From here on, just follow the instructions in the application. You will be asked to provide your information and set up secure access to your ASRS account, where you track your contributions, make updates online and be kept informed about your retirement plan.

If you are already an ASRS member, please provide your latest information. This is required so your employer can verify ASRS eligibility.

ASBAIT

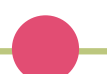
Arizona School Boards Association Insurance Trust

Employee Assistance Program (EAP)

Alliance Work Partners is
here for you as life happens.

AWP is proud to serve as your EAP, offering you and your household valuable, *confidential* services at no cost to you.

Your benefits are designed to help you manage daily responsibilities, major events, work stresses, or any issue affecting your quality of life.



All benefits can be accessed by calling:

toll free

1-800-343-3822

PLEASE PROVIDE YOUR DISTRICT'S NAME WHEN YOU CALL.

TDD

1-800-448-1823

teen line

1-800-334-TEEN (8336)

We are available to take your call 24 hours a day, 7 days a week.

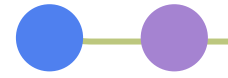
Visit your EAP website at

awpnow.com

and create a customized account.

Go to
https://www.awpnow.com
Select "Access Your Benefits"

Registration Code:
AWP-ASBAIT-2811



Your EAP Benefits:

LawAccess

Legal and Financial services provided by a lawyer or financial professional specializing in your area of concern. Available online or by telephone.

HelpNet

Customized EAP website featuring resources, skill-building tools, online assessments and referrals.

WorkLife

Resources and referrals for everyday needs. Available by telephone.

Nurse Support

Expert advice on health issues and when/how to address them.

SafeRide

Reimbursement for emergency cab fare for eligible employees and dependents that opt to use a cab service instead of driving while impaired.

1 to 5 Counseling Sessions

Per problem, per year. Short-term counseling sessions which include assessment, referral, and crisis services. *(Same day appointments available for urgent/crisis callers, or facilitation of immediate hospitalization)*

Newsletters
Webinar Training Series
Tips for Everyday Living

Here for you as life happens …

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Employee Assistance Program (EAP)

Criteria for Benefits Eligibility

Full Benefits:

- Employee, retiree, married/divorced spouse, partner, significant other
- Any household member, regardless of age or relationship, residing in employee's home, including significant other and their children
- All covered employees may bring anyone with them to their authorized/covered sessions regardless of relationship to employee.
- Children and grandchildren, **age 26 or under**, residing in US or Puerto Rico. This includes children and grandchildren of significant other or partner.
- Any person meeting benefit eligibility prior to lay-off or termination of an employee will continue to be eligible for benefits up to 6 months from the date of employee's lay-off or termination. Benefits are extended for 6 months from date of employee's call within this timeframe.

Assessment & Referral:

- Children and grandchildren **age 27 and over** of employee, married/divorced spouse, partner, or significant other living outside employee's home
- Employee instructed by law to receive court-ordered counseling
- All crisis cases (suicidal/homicidal, domestic violence, chemical dependence, substance abuse, child/elderly abuse) not otherwise covered
- Any person meeting benefit eligibility prior to lay-off or termination of an employee will continue to be eligible for assessment and referral after 6 months and up to 1 year from the date of employee's lay-off or termination. Benefits are extended 1 year from date of employee's call within this timeframe.

Information & Referral:

- Anyone contacting Alliance Work Partners regardless of contract status

Children under the age of 18 must have a written, signed release by their guardian who has custody (whether living in the home or not) to attend counseling on their own. This release is given to their affiliate provider. Divorced parents who bring their children in for counseling must bring a copy of their divorce decree or have signed permission from the other parent before bringing a child into counseling. Grandparents who bring their grandchildren into counseling must have proof of guardianship or written permission from the child's parents.

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