LAKE HAVASU UNIFIED SCHOOL DISTRICT

Open Enrollment 2020-21

Notes:

Northwest AZ
EMPLOYEE BENEFIT TRUST

Lake Havasu Unified School District Open Enrollment Guide

For plan year July 1, 2020 – June 30, 2021

Elections you make during open enrollment will become effective July 1, 2020.

This booklet contains important information regarding your benefits for the plan year beginning July 1, 2020. We believe you will find it very helpful in understanding your benefit options.

Every employee must enroll for coverage in the IVisions self-service Benefits Portal by 5:00 p.m. on Friday, May 15, 2020. If you do not enroll before the deadline, you will not have Medical/Rx, Dental and/or Vision insurance as of July 1, 2020. Flexible Spending Accounts (FSA) and Dependent Day Care (DDC) must be re-elected every plan year. Failure to re-elect these benefits during open enrollment forfeits your ability to participate in these programs during the next plan year.

Dependent eligibility documents (see page 8 of this book) can be sent via interoffice mail or email to Cheri Tropple at Cheri.Tropple@lhusd.org or by fax to 928.505.6999 and must be received no later than 5:00 PM on Friday, May 15, 2020 to complete your benefit enrollment. Failure to provide these documents by the deadline will result in your dependents not being eligible for coverage until the next plan year begins.

If you do not have computer access or need assistance with understanding your benefit options, please schedule an appointment to meet with Cheri Tropple by calling 928.505.6930 or email Cheri.Tropple@lhusd.org.

The IVisions benefit election tool is simple to use and will make open enrollment as streamlined as possible.

Table of Contents:

Contact Information:

Medical Claims Administrator:

AmeriBen will be the Medical Claims Administrator. They can be contacted at 1.877.635.2909 or by visiting www.myAmeriBen.com. More information on AmeriBen can be found on page 11.

Arizona and National Provider Network:

Blue Cross Blue Shield of Arizona will continue to be the Arizona provider network. You will now have access to the BCBS Blue Card Nationwide Network for medical care outside of Arizona. A list of providers can be found by visiting this link www.azblue.com and selecting EPO as your Network. Enter the location, then search. You will be searching the National Network. For step-by-step instructions on how to find an in-network provider refer to page 11. You may also use the link from www.MyAmeriben.com or by calling AmeriBen at 1.877.635.2909.

Prescription Benefit Plan:

Navitus will be the prescription benefit manager. To register, access your claim information and view the formulary visit www.Navitus.com. Customer service by telephone is available 24/7 except Thanksgiving and Christmas day at 855.673.6504. For more information on Navitus and how your current prescriptions may be affected see page 13.

Dental Coverage:

Ameritas will continue to be your dental coverage provider but your plan will change, and you will receive a new ID card. You can find in-network dental providers by calling 1.800.487.5553. For an outline of plan highlights see page 25.

Vision Coverage:

Your vision coverage provider will change to VSP and is administered by Ameritas. You can find in-network vision providers at www.vsp.com. See page 26 for highlights.

Teladoc:

Teladoc will provide telephonic/video physician consultations. Teladoc doctors can diagnose, recommend treatment, and prescribe medication when necessary. For more information on Teladoc, visit www.teladoc.com, or to phone a doctor call 1.800.362.2667. Please see page 20 of this book for additional information.

BlueCare Anywhere:

BlueCare Anywhere is another option for face to face with a board-certified doctor any time, night or day. Use your computer, tablet, or smartphone to start a visit today. Download the BlueCare Anywhere mobile app or visit BlueCareAnywhereAz.com. See page 21 for more information.

Medical Review (Pre-certification):

American Health Group (AHG) will continue to handle all pre-certification. To contact AHG about pre-certification or case management call 1.800.847.7605 or 1.602.265.3800. Please see page 10 of this book for additional information.

Health Savings Account (HSA):

HSA Bank will be the new vendor for Health Savings Accounts and can be reached by calling Client Assistance Center: 1.800.357.6246 or logging on to www.hsabank.com. Members with existing HSA accounts can roll their current account balance into the HSA Bank account. See page 27 of this book for additional information.

Flexible Spending Account (FSA) & Dependent Day Care Account (DDC):

Ameriflex will be your Flexible Spending Accounts (FSA) and Dependent Day Care accounts (DDC) provider. See page 29 of this book for additional information. AmeriFlex can be reached by calling 1.888.868.3539 or logging on to www.myameriflex.com.

Basic Life, Voluntary Life, and AD&D:

The Standard Insurance Company will be your Basic Life, Voluntary Life (VTL) and Accidental Death & Dismemberment benefits provider. You may contact Standard Insurance at 1.800.447.3146 or www.standard.com. See page 30 of this book for additional information including how your in-force VTL through Guardian will transfer to The Standard.

Employee Assistance Program (EAP) Provider:

EAP Preferred will be your Employee Assistance Program provider. You may contact EAP Preferred at 1.800.327.3517 or www.eappreferred.com. See page 26 of this book for additional information.

NAEBT Trust Administrator:

ECA provides Trust Administration services to the Trust as well as assistance with member questions, concerns, or issues.

You may contact Stephanie Moore at 928-753-4700 Ext. 303 or stephaniem@ecollinsandassociates.com or Robert Dover at 928-753-4700 Ext. 307 or robertd@ecollinsandassociates.com.

Benefit Enrollment:

Open enrollment will be from April 27, 2020, through 5:00 PM on May 15, 2020, for changes effective July 1, 2020.

Mid-Year Changes to Your Benefit Elections

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

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

For a full list of qualifying events, please refer to your Summary Plan Document (SPD). A copy of the SPD can be found on the website at www.havasu.k12.az.us under staff. You MUST request enrollment using the IVisions online enrollment system within 31 days of the Life Event.

Medical/Rx Cards:
Participants will receive new medical/Rx cards at your home address. If you need an additional card:

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

Dental/Vision Cards:

Participants will receive new dental and vison cards. If you need an additional card:

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

Dependent Eligibility:

Dependent Certification: Employees who plan to enroll dependents for the 2020-21 plan year to the medical/Rx, dental/vision, basic life, voluntary life or accidental death and dismemberment plans will be required to provide documentation that the person enrolled is a legal dependent. Examples include marriage certificates, birth certificates, tax returns, court orders regarding custody or guardianship, or any other documents that verify dependent status. Failure to submit this information during your initial enrollment or open enrollment, as applicable, will result in your dependents not being enrolled for benefits. Eligible dependents can be covered on Medical/Rx, Dental/Vision and Life plans through the last day of the month of their 26th birthday. For Retirees, qualified dependents include the spouse and/or child of a retiree if the dependent was covered under the Plan as of the day before the eligible retiree's retirement.

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

General Medical Plan Information:

Medical/Rx Benefit Terms & Billing

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

What is a deductible? The deductible is the amount of covered medical expenses the participant pays each plan year before benefits are paid by the plan. For example, if the deductible is $600, then you must pay the first $600 of the covered medical costs before the plan will pay. The deductible amount must be met first before coinsurance applies.

The HDHP has a $1,400 per participant and $2,800 per family deductible for in-network providers and a separate $1,400 per participant and $2,800 per family deductible for out-of-network providers. The HDHP deductible is non-embedded meaning that when enrolled in any tier other than employee only, you must meet the family deductible before claims are paid. The EPO Plan has a $600 per participant and $1,800 per family deductible for in-network providers. The EPO deductible is embedded. This means that participants satisfy the $600 deductible individually even if they are in a tier other than employee only.

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

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

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

The EPO Plan has a $7,900 per participant and $15,800 per family maximum out-of-pocket. The maximum out of pocket on the EPO plan is embedded. This means the plan will cover 100% of the approved charges for a participant once the individual participant meets $7,900. The plan will cover 100% of approved charges once employee plus children, spouse or family reaches $15,800 in the plan year.

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

physician who will send a separate bill for payment.

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

Eligibility, Pre-Certification Requirements, and Case Management:

Verification of Eligibility

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

Medical Benefits

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

Pre-Certification Requirements

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

Case Management

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

NAEBT Vendor Information

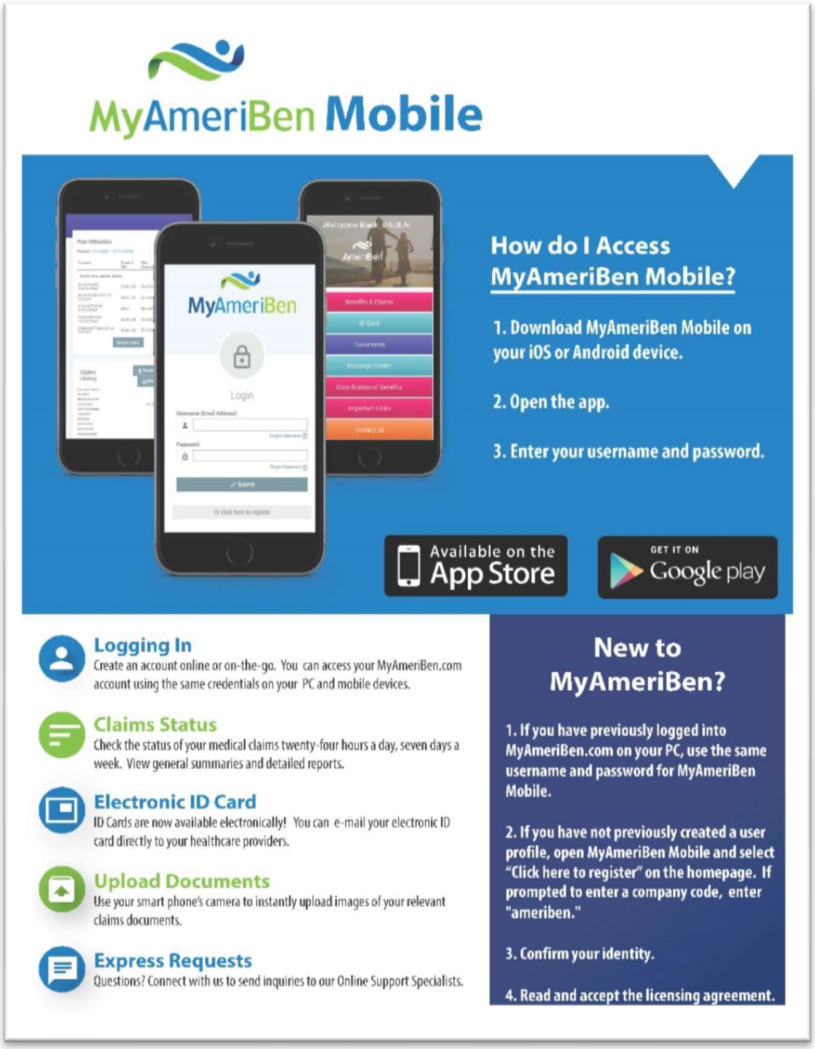
Blue Card Network

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

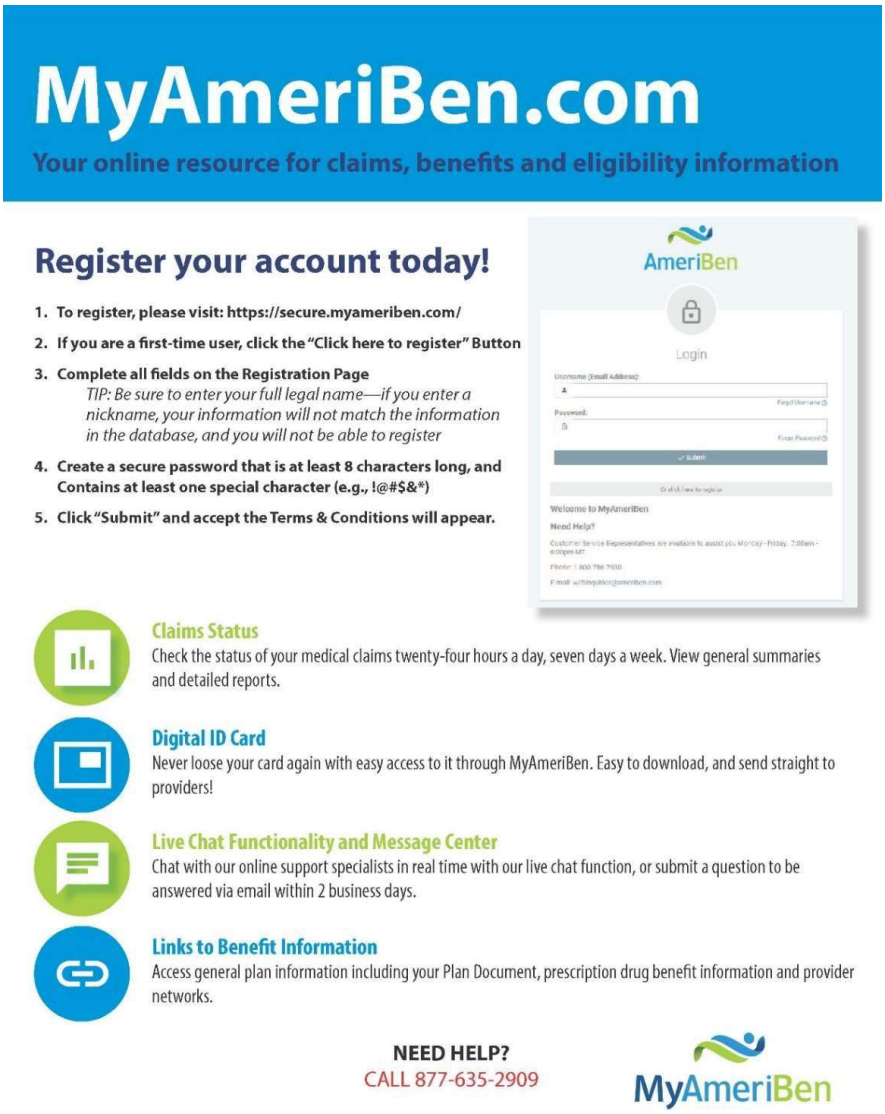
AmeriBen

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

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



After you visit the doctor, in-network providers send the claim to BCBSAZ for repricing. BCBSAZ discounts it based on the agreement they have with that provider. Once repriced, it is sent to AmeriBen for processing then authorizes BCBSAZ to process the payment. AmeriBen compares the billing codes to the Summary Plan Description to verify the charges are for covered services. If approved, it is processed for payment. The provider will receive a check, and the participant will receive an Explanation of Benefits (EOB) explaining how the claim was paid. If you receive a bill from your provider and do not receive and EOB from AmeriBen, you should log into your personal MyAmeriBen account or call AmeriBen at 1.877.635.2909 to inquire if they have received the claim or you can contact your provider to verify they have your correct insurance billing information. Non-network providers send their claims directly to AmeriBen for processing or payment. If it is a large claim (Over $5,000), AmeriBen will attempt to negotiate with the facility or provider for a discount. Many times, they are successful, and this saves money for both the Trust and the Participant. If you have questions or would like assistance with understanding the plan, please call AmeriBen toll-free at 1.877.635.2909. You will be able to register on the MyAmeriBen site starting July 1, 2020.



Navitus

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

Pharmacy Benefit F.A.Q.

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

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

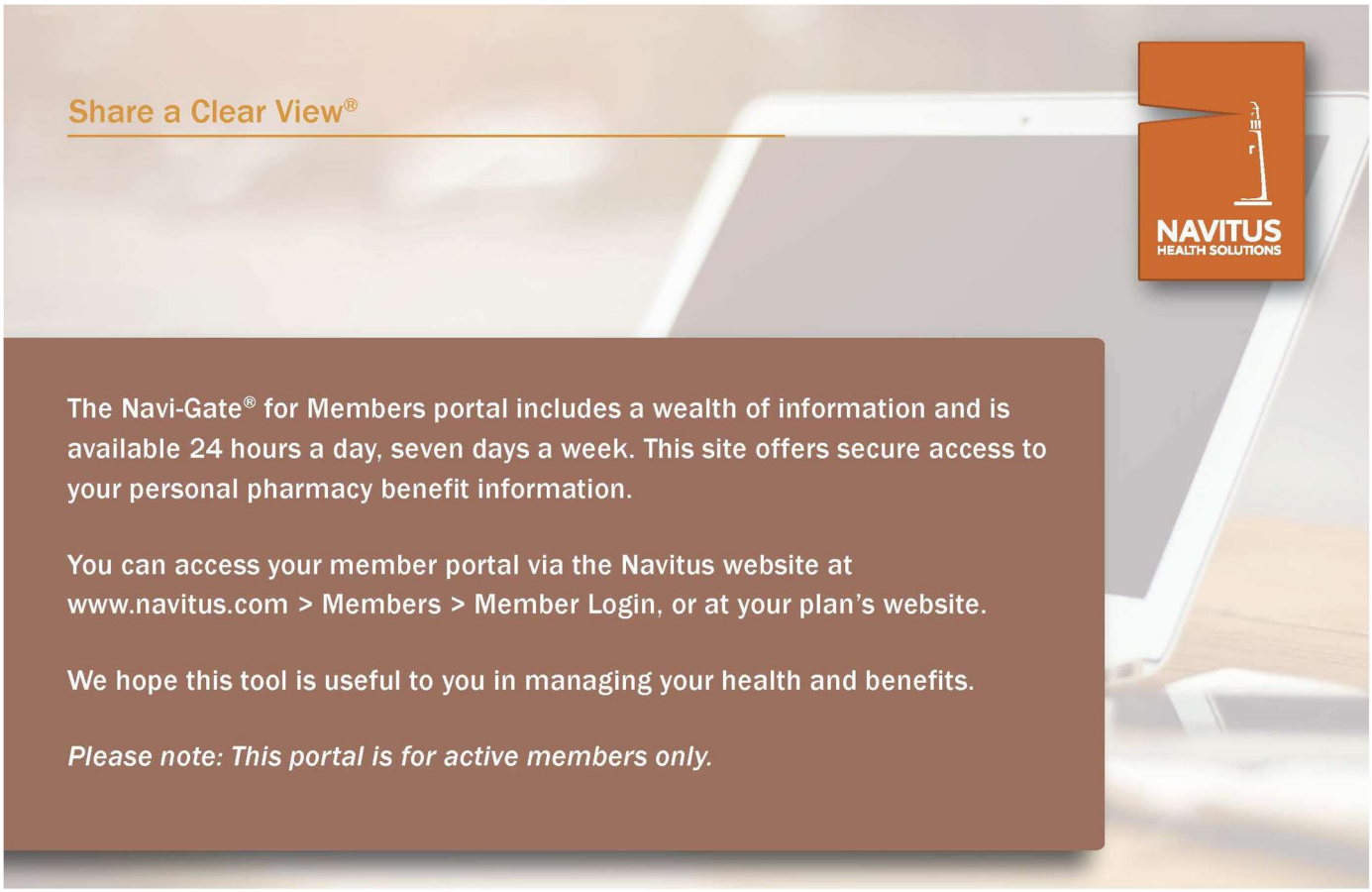
Where can I find my formulary? The list of drugs covered by your benefit is available on our website at www.navitus.com then select “Members” at the top of the page. In the middle of the page, you will see the Member Portal Login.

How do I get additional Pharmacy ID Cards? You can request additional medical/Rx ID cards through the AmeriBen portal.

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

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

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



Using the Costco Mail-Order Pharmacy

Mail Order

Getting your medications through mail order is simple and convenient. It saves you and the plan money too. Starting. Costco will continue to be your Mail Order Pharmacy. You do not need to be a Costco member to utilize the mail order service or to pick up a prescription in person. Your current mail order prescription will not be transferred.

It is easy to enroll:

Step 1: Register online at www.pharmacy.costco.com. Under "New Patients" create an account. Enter all the required information. You can also complete the mail order enrollment form available online and mail it to Costco.

Step 2: Fill your prescription. Request your new prescription online at www.pharmacy.costco.com. Your provider can provide the prescription by calling 1.800.607.6861, faxing it to 1.888.545.4615 or e-prescribing it. Step 3: Obtain refills online at www.pharmacy.costco.com, by calling 1.800.607.6861 or by enrolling in the auto- refill program.

NEW PROGRAM
EFFECTIVE 7/1/2020!!

Northwest AZ
EMPLOYEE BENEFIT TRUST

PRESCRIPTION DRUG CO-PAY MAX PROGRAM

Applies only to specialty medications obtained through the Navitus Specialty Pharmacy Lumicera.

WHAT DOES THIS MEAN FOR ME?

- If you are a EPO plan participant instead of paying your 20% up to $150 co-pay, your co-pay will be $0.

- If you are a HDHP participant instead of paying the full cost of your prescription until you have met your deductible/Max Out-of-Pocket, your cost-sharing will be $0.

IF YOUR MEDICATION QUALIFIES, YOU WILL BE AUTOMATICALLY ENROLLED.

High Deductible Health Plan (HDHP)

Outline of Benefits

MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
Plan-Year Deductible per participant Enrolled in Employee Only (EE)	$1,400	$1,400
Plan-Year Deductible per family Enrolled in any tier other than EE Only	$2,800	$2,800
Out-of-Pocket Maximum per participant per family	$3,000 $6,000 (Includes Deductible)	Unlimited Unlimited (Includes Deductible)
Inpatient Hospital	80% After Deductible	50% After Deductible
Outpatient Facility	80% After Deductible	50% After Deductible
Office Visits	80% After Deductible	50% After Deductible
Urgent Care Facility	80% After Deductible	50% After Deductible
Preventive Services (as mandated by the federal law)	100% Deductible Waived	Not Covered
Chiropractic Care (limited to 40 visits)	80% After Deductible	50% After Deductible
Diagnostic testing, X-ray and Lab Services (outpatient)	80% After Deductible	50% After Deductible
Maternity	80% After Deductible	50% After Deductible
Emergency Room Non-Emergency Medical Condition	80% After Deductible Not Covered	80% After Deductible Not Covered
Mental Health & Substance Abuse Inpatient (limited to 2 inpatient confinements per lifetime and 30- day plan-year maximum)	80% After Deductible	50% After Deductible
Mental Health & Substance Abuse Outpatient (limited to 45 visits per plan-year)	80% After Deductible	50% After Deductible

Exclusive Provider Organization (EPO)

Outline of Benefits

MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
Plan-Year Deductible per participant per family	 $600 $1,800	 Not Covered Not Covered
Out-of-pocket Maximum per participant per family	 $7,900 $15,800	 Not Covered Not Covered
Inpatient Hospital	80% After Deductible	Not Covered
Outpatient Facility	80% After Deductible	Not Covered
Office Visits Primary Care Specialist	 $30 Co-pay $50 Co-pay	 Not Covered Not Covered
Urgent Care Facility	$50 Co-pay (Deductible waived)	Not Covered
Preventive Services (as mandated by the Federal law)	100% No Deductible	Not Covered
Chiropractic Care (limited to 40 visits)	$30 Co-pay (Deductible waived)	Not Covered
Maternity	80% After Deductible	Not Covered
Emergency Room Non-Emergency Medical Condition	$150 Co-pay then 80% After Deductible Not Covered	True Emergencies are covered at in-network benefit level Not Covered
Mental Health & Substance Abuse Inpatient (limited to 2 inpatient confinements per lifetime and 30- day plan-year maximum)	80% After Deductible	Not Covered
Mental Health & Substance Abuse Outpatient (limited to 45 visits per plan year)	$30 Co-pay PCP/$50 Co-pay Specialist. No Deductible	Not Covered
Free-standing Laboratory Facility	100% No Deductible	Not Covered
Free-standing Radiology Facility	80% After Deductible	Not Covered
All Other Locations (except office visit)	80% After Deductible	Not Covered

Prescription Plan

Outline of Benefits

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

2020-21 Rates

Lake Havasu Unified School District 2020-21 Rates and Contributions

EPO	Monthly Premium	Employer Contribution		Employee Contribution	
		24 Pays	18 Pays	24 Pays	18 Pays
Employee Only	$728.16	$364.08	$485.44	$0.00	$0.00
Employee + S	$1,401.71	$465.11	$620.15	$235.74	$314.32
Employee +1C	$1,135.89	$466.01	$621.35	$101.93	$135.91
Employee + C	$1,362.34	$506.77	$675.69	$174.40	$232.53
Employee + F	$1,912.73	$636.53	$848.71	$319.83	$426.45
HDHP					
Employee Only	$670.91	$335.46	$447.27	$0.00	$0.00
Employee + S	$1,286.13	$427.74	$570.32	$215.33	$287.10
Employee +1C	$1,047.18	$429.52	$572.70	$94.07	$125.42
Employee + C	$1,250.72	$465.91	$621.22	$159.45	$212.60
Employee + F	$1,745.47	$582.60	$776.81	$290.13	$386.84
Dental/Vision					
Employee Only	$48.67	$24.34	$32.45	$0.00	$0.00
Employee + S	$95.71	$24.34	$32.45	$23.52	$31.36
Employee +1C	$70.76	$24.34	$32.45	$11.05	$14.73
Employee + C	$97.26	$24.34	$32.45	$24.30	$32.39
Employee + F	$139.78	$24.34	$32.45	$45.56	$60.74
Life & AD&D	$40K Employee, $10K Spouse $5k Child with matching AD&D				
Employee Only	$8.00	$4.00	$5.33	$0.00	$0.00
Employee + S	$9.70	$4.85	$6.47	$0.00	$0.00
Employee +1C	$8.25	$4.13	$5.50	$0.00	$0.00
Employee + C	$8.25	$4.13	$5.50	$0.00	$0.00
Employee + F	$9.95	$4.98	$6.63	$0.00	$0.00

EPO	Monthly Premium	District Contribution	ASRS Contribution	Retiree Contribution
Retiree Only	$1,094.12	$699.76	$150.00	$244.36
Retiree + S	$2,142.67	$699.76	$260.00	$1,182.91
Retiree +1C	$1,704.08	$699.76	$260.00	$744.32
Retiree + C	$2,077.70	$699.76	$260.00	$1,117.94
Retiree + F	$2,985.86	$699.76	$260.00	$2,026.10
HDHP				
Retiree Only	$999.65	$699.76	$150.00	$149.90
Retiree + S	$1,951.96	$699.76	$260.00	$992.20
Retiree +1C	$1,557.69	$699.76	$260.00	$597.93
Retiree + C	$1,893.54	$699.76	$260.00	$933.78
Retiree + F	$2,709.88	$699.76	$260.00	$1,750.12
Dental/Vision				
Retiree Only	$48.67	$34.07	$0.00	$14.60
Retiree + S	$95.71	$34.07	$0.00	$61.64
Retiree +1C	$70.76	$34.07	$0.00	$36.69
Retiree + C	$97.26	$34.07	$0.00	$63.19
Retiree + F	$139.78	$34.07	$0.00	$105.71
Life	$20K Retiree			
Retiree Only	$4.00	$2.80	$0.00	$1.20

Teladoc – Talk to a doctor anytime

Quality care is only a call or click away. U.S. board-certified doctors can resolve many of your medical issues, 24/7 and 365 days a year, via phone or online video consults from wherever you are. Teladoc qualifies as an expense for HSA and FSA accounts. If you are on the HDHP plan, a call is $49 and applies to your deductible. After you have met your deductible, HDHP participants will receive 100% reimbursement for Teladoc consultations. If you are on the EPO plan, your first (4) calls to Teladoc per plan participant per plan year will be at no charge; consults after the first four (4) will be subject to a $10 co-pay.

Behavioral Health: EPO participants will pay $50 for consultations with a Psychiatrist. HDHP participants will pay $200 for the initial evaluation and $95 per consultation for ongoing visits to consult with a Psychiatrist. EPO participants will pay $30 co-pay to consult with a Licensed Clinical Social Worker, Psychologist, Counselor or Therapist. HDHP participants will pay $85 per consultation with a Licensed Clinical Social Worker, Psychologist, Counselor or Therapist.

Dermatology Service: Teladoc doctors can provide treatment for many common skin problems including acne, rash, poison ivy, eczema, skin infections, ringworm, athlete's foot, lice, shingles, etc. Simply take up to five (5) photos of the issue and send to Teladoc. You'll receive a response within 48 hours. EPO participants will pay $50 per consult; HDHP participants will pay $75 per consult.

www.teladoc.com or 1.800.362.2667

BlueCare Anywhere™

Virtual Doctor Visits Any Day, Any Time.

Frequently Asked Questions

What is BlueCare Anywhere?

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

What services are offered?

MEDICAL

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

COUNSELING

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

PSYCHIATRY

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

EPO: First four consultations covered 100%, then $10 copay for each additional consultation.

HDHP: $49 per consultation, $59 per consultation effective 1/1/2021.

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

How does it work?

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

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

How much does it cost?

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

When would I use BlueCare Anywhere?

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

Can I use BlueCare Anywhere when I'm traveling?

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

What computer requirements are needed?

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

Can the doctor prescribe medication?

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

Who are the doctors?

Medical doctors available on **BlueCare Anywhere**:

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

How do I add a spouse or other family member?

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

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

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

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

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

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Associations

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BlueCare Anywhere

Quick Tips

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

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

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

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

2 Know when to use it

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

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

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

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

3 See a doctor or make an appointment

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

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

4 Get treated

- You will see when the doctor dials into the video chat session.
- The doctor will talk with you about your health concern just like during a regular office visit.
- You can use the camera on your computer or mobile device to provide close-up views.
- The doctor will give you treatment options and may send a prescription to the pharmacy you've selected, if needed.
- Need a sick slip or documents to go back to work or school? The doctor can provide this, if medically appropriate.

5 After your visit

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

Share

CARE IS AVAILABLE NOW.

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

Download on the App Store | Google play

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

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Vision Plan Highlights

Northwest Arizona Employee Benefit Trust (NAEBT)

Vision Highlight Sheet
Policy # 301339

Ameritas

Focus® Plan Summary **Effective: 7/1/2020**

	VSP Network	Out of Network
Deductibles		
	$10 Exam $0 Eye Glass Lenses or Frames*	$10 Exam $0 Eye Glass Lenses or Frames*
Annual Eye Exam	Covered in full	Up to $47
Lenses (per pair)		
Single Vision	Covered in full	Up to $48
Bifocal	Covered in full	Up to $69
Trifocal	Covered in full	Up to $85
Lenticular	Covered in full	Up to $125
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	15% discount See Additional Focus Features.	No benefit
Elective	Up to $150	Up to $150
Medically Necessary	Covered in full	Up to $210
Frames	$105	Up to $45
Frequencies (months)		
Exam/Lens/Frame	12/12/12 Based on date of service	12/12/12 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*

Lens Options (member cost)*

	VSP Network	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Trifocal allowance.
Progressive Lens options fully covered after copay:	Standard Progressive Lenses $50.00 Premium Progressive Lenses $80.00 – 90.00 Custom Progressive Lenses $120.00-$160.00	Up to Lined Trifocal allowance.
Solid Plastic Dye	Covered in full	Up to $5
Plastic Gradient Dye	Covered in full	Up to $5
Photochromatic Lenses (Glass & Plastic)	Covered in full	Up to $5
Scratch Resistant Coating	$15-$29	No benefit
Anti-Reflective Coating	$39-$75	No benefit
Ultraviolet Coating	$14	No benefit
Lasik or PRK	Average discount of 15% off retail. See Additional Focus Features.	No benefit

**Lens Option member costs vary by prescription and option chosen.*

Eye Care Plan Member Service

Focus eye care from Ameritas features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195
- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com/member-Network is VSP
View plan benefit information at: vsp.com

Dental Plan Highlights

Northwest Arizona Employee Benefit Trust (NAEBT)

Dental Highlight Sheet
Policy # 301339

Ameritas

Dental Plan Summary **Effective: 7/1/2020**

Coinsurance	**In Network Only**
Type 1	100%
Type 2	80%
Type 3	80%
Deductible	$50/Plan Year Type 2 & 3
	Waived Type 1
	3 Family Maximum
Maximum *(per person)*	$3,000 per plan year
Allowance	Contracted Fee
Waiting Period	*6-months Late Entrant Type 3

Orthodontia Summary - Child Only Coverage-must be banded by age 17

	IN NETWORK ONLY
Deductible Amount-Once per lifetime	$50
Allowance	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	*6-months Late Entrant

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

In Network Only

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Restorative Amalgams	• Onlays
• Bitewing X-rays (2 per benefit period)	• Restorative Composites	• Crowns
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Endodontics (nonsurgical)	(1 in 5 years per tooth)
• Periapical X-rays	• Endodontics (surgical)	• Crown Repair
• Cleaning (2 per benefit period)	• Periodontics (nonsurgical)	• Implants
• Fluoride for Children 18 and under	• Periodontics (surgical)	• Prosthodontics (fixed bridge; removable
(1 per benefit period)	• Denture Repair	complete/partial dentures)
• Sealants (age 18 and under)	• Simple Extractions	(1 in 5 years)
• Space Maintainers	• Complex Extractions	
	• Anesthesia	

To find a provider, please visit our website at www.ameritas.com

Employee Assistance Program (EAP)

Your EAP will help you navigate through the ups and down of life.
You and your household members are eligible to use these no-cost CONFIDENTIAL COUNSELING SERVICES EAP Preferred offers six [6] face to face and /or telephonic sessions and 24/7 Crisis Support.

Clinical assistance with: Stress, Anxiety, Depression, Marital/Relationship Issues, Adolescent/ Family Issues Grief /Loss, Substance Abuse and Gambling

Resources and Referrals for:
Legal – 30-minute consultation and 25% discount total bill.
Financial
Child/Elder Care
ID Theft

EAP PREFERRED
EMPLOYEE ASSISTANCE PROGRAMS & BEHAVIORAL HEALTH SERVICES
CONSISTENT QUALITY • CONSTANT VALUE℠

How to Access: Call to schedule an appointment Monday through Friday 8:00 am to 5:00 pm 602.264.4600 Press *2, for 24-hour Crisis Support press*5 or go online to www.eappreferred.com Username: NAEBT Password: eappreferred

	THEME	ONLINE SEMINAR* *For clients with Advantage Complete or Enhanced Web	DESCRIPTION Seminars can be found on your home page, or you can search for them by title.
JAN	Financial Goals	*Your Financial Checkup* Available on Demand Starting Jan 21st	Walk through a "financial checkup", guiding you through the necessary steps to examine your finances.
FEB	Setting Realistic Expectations	*Managing Workplace Stressors* Available on Demand Starting Feb 18th	Get information and strategies to address and manage professional stressors effectively.
MAR	Professional Development	*Planning for Professional Growth* Available on Demand Starting Mar 17th	Discuss the four stages of professional careers and get tools to develop a self-assessment plan that can lead to your career growth.
APR	Practical Parenting	*Effective Communication With Children* Available on Demand Starting Apr 21st	Learn about different communication styles and how to communicate effectively, starting in early childhood.
MAY	Accepting Aging	*Accepting Aging: Yourself and Others* Available on Demand Starting May 19th	Examine "normal" age-related changes and identify ways for you to come to terms with your own aging.
JUN	Conflict Resolution	*Say What You Mean the Right Way* Available on Demand Starting Jun 16th	Identify barriers to clear communication and discuss how to apply tips for effective communication.
JUL	Adventuring and Exploring	*Explore New Horizons and Expand the Mind* Available on Demand Starting Jul 21st	Discover the possibility and promise of seeking and exploring new horizons.
AUG	Outsource Your To-Do List	*Outsourcing Your To-Do List* Available on Demand Starting Aug 18th	Learn to outsource the more thankless chores and discover a world of potential, leading towards a happier and more fulfilling way of life.
SEP	Work and Family Balance	*The Secret to Work-Life Balance* Available on Demand Starting Sep 15th	Uncover the secret to securing a healthy work and family balance.
OCT	Mental Strength	*The Mental Strength Workout* Available on Demand Starting Oct 20th	Learn skills and strategies to exercise the power of your mind and increase your mental fortitude.
NOV	Healthy Ways to Cope with Stress	*Building Resilience Muscles* Available on Demand Starting Nov 17th	Learn resilience by understanding yourself and identifying the mental obstacles that get in your way.
DEC	Being Grateful	*Know Your Strengths* Available on Demand Starting Dec 15th	Explore how confidence and a strengths-mindset can enable you to respond more creatively to challenges.

WHATEVER YOU NEED, WE ARE HERE TO HELP.
Just call or log on to get started.

YOUR EMPLOYEE SUPPORT PROGRAM
Available any time, any day, your Employee Support Program is a free, confidential benefit to help you balance your work, family, and personal life.

TOLL-FREE: 800-327-3517
WEBSITE: eappreferred.com
USERNAME: NAEBT
PASSWORD: eappreferred

EAP PREFERRED | An IBH Company
Northwest AZ

Tax-Free Savings for Medical Expenses (HSA)

Health Savings Account (HSA)

Re-enrollment is not typically required for an HSA, however due to the change from Healthcare Bank to HSA Bank a new enrollment form will be required this plan year.

What is an HSA?

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

How Does an HSA Work?

An HDHP offers a lower monthly premium in exchange for a higher deductible. The money you would normally spend on monthly premiums can now be contributed on a pre-tax basis to your HSA account. You will receive a debit card to use for qualified medical expenses, which will draw from your HSA. Distributions from your HSA are tax-free when used to pay for qualified medical expenses. The 2020 maximum contribution for single coverage is $3,550, and family is $7,100. HSA participants who are 55 or older can contribute an additional $1,000, or $4,550 for single coverage and $8,100 for family coverage. Lake Havasu Unified School District will be moving to HSA Bank for all HSA accounts. The District will contribute to each HSA account in the amount of $687 this year in equal installments in accordance with your established payroll plan (24 or 18). Please note, HSA contribution limits operate on a calendar-year basis. A participant can elect to contribute the maximum amount from July 1, 2020 - December 31, 2020; however, to avoid tax issues, the individual must remain on the HDHP through the full plan year following elections.

How can I save money with an HDHP & HSA?

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

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

Some of the most common expenses include:

Deductible	Contact Lenses	Eyeglasses	Over-the-counter medications
LASIK Surgery	Office visit co-pays	Dental Treatment	Out-of-pocket expenses
Prescription Drugs	Chiropractor Visits	Vaccinations	

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

What are the benefits of having an HSA account?

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

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

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

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

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

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

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

Tax-Free Savings for Medical Expenses (FSA)

Flexible Spending Account (FSA)

An FSA allows employees to designate a certain amount of their taxable income on a pre-tax basis to pay for their out of pocket health care expenses such as deductibles, co-payments, co-insurance, dental and vision expenses. Participating in Lake Havasu Unified School District's FSA will allow you to pay less in taxes and keep more of your hard-earned money. **FSA and DDC deductions will be taken over 18 pay periods.**

The 2020 maximum contribution amount is $2,750. The FSA is an annual election and MUST be elected annually via the IVisions online enrollment system to participate. FSA's are pre-funded, which means that the total amount of your election will be available to you on July 1, 2020. FSA accounts are "use it or lose it" programs. You will gain the most savings if you plan carefully and elect only what you estimate your eligible expenses will be. At the end of the plan year, unused funds are forfeited. Please note, eligible expenses are clearly defined by the IRS - for more information on eligible expenses, visit www.irs.gov/publications/p502/ index.html.

NOTE: If you enroll in the HDHP and enroll in a Health Savings Account the IRS prohibits you from enrolling in an FSA.

Tax-Free Savings for Dependent Care

Dependent Day Care (DDC)

Employees may also elect to participate in a DDC account which allows them to pay for dependent care expenses with tax-free dollars for eligible dependents. The maximum contribution amounts are $5,000 or $2,500 if married and are filing a separate tax return. The DDC is an annual election and MUST be elected annually to participate. DDC accounts are not pre-funded. Funds are accessible after bi-weekly Payroll deductions. DDC eligible expenses are for children under the age of 13 and dependents of any age who are physically or mentally unable to care for themselves. By enrolling in this plan, you save money on daycare expenses incurred so that you (and your spouse, if married) can work, look for work, or attend school on a full-time basis. At the end of the plan year, unused funds are forfeited. **FSA and DDC deductions will be taken over 18 pay periods.**

NOTE: Employees enrolled in the EPO, or the HDHP medical/Rx plan are eligible to participate in the DDC.

AmeriFlex administers Medical FSA and DDC accounts and can be reached by calling 1.888.868.3539 or logging on to www.myameriflex.com.

Basic Life Insurance/AD&D

Basic Life Insurance

Basic Life Insurance will be administered by The Standard Insurance Company. Each employee will be provided $40,000 in life insurance and $40,000 in AD&D; spouses enrolled in medical/Rx will be provided $10,000 in life insurance and each eligible child enrolled in medical/Rx will be provided $5,000 in life insurance.

Voluntary Life Insurance (VTL)

Voluntary Life Insurance is available to employees who want to supplement their basic life insurance benefits. Premiums for employees and dependents will be paid through payroll deductions and are offered at discounted group rates. Coverage can be purchased from $10,000 to $500,000 in increments of $10,000. Life insurance benefits cannot exceed five (5) times your annual salary, including the $40,000 basic life coverage provided by the District. A legal spouse can also be covered, but the insurance shall not exceed 100% of the employee's life insurance. Children can be covered in amounts of $5,000 or $10,000. In order to have dependent coverage, the employee must be enrolled. All coverage is subject to review and approval by medical underwriting. You will be required to complete the applicable medical underwriting forms when coverage requested exceeds the guaranteed issue amounts.

If you currently have VTL through the Guardian, those amounts will transfer to The Standard effective July 1, 2020 at the rate shown in the chart below based on your age on July 1, 2020.

If your existing VTL coverage is less than the guaranteed issue amounts below, you may increase your coverage to these amounts without medical underwriting.

Guaranteed Issue Amounts:

Employee $100,000

Spouse $20,000

Child(ren) $5,000 or $10,000

Age Bands	Rate per $1,000 of Coverage
29 and under	$0.07
30-34	$0.08
35-39	$0.10
40-44	$0.14
45-49	$0.21
50-54	$0.35
55-59	$0.57
60-64	$0.75
65-69	$1.30
70-74	$2.30
75 and over	$8.74

Voluntary AD&D Insurance

Employees are offered this benefit through The Standard Insurance Company. Premiums for employees and dependents will be paid through payroll deductions and are offered at discounted group rates. Employee coverage can be from $10,000 to $500,000 in increments of $10,000. Dependents can be covered as follows:

- Spouses only: 50% of employee's Voluntary AD&D coverage amount
- Child(ren) only: 10% of employee's Voluntary AD&D coverage amount, not to exceed $25,000
- Spouses and child(ren): 40% of employee's Voluntary AD&D coverage amount for the spouse and 5% for each child

Additional Information

Section 125 Benefit Plan

Lake Havasu Unified School District's Section 125 Benefit Plan, effective July 1, 2020 through June 30, 2021, is available to all benefit eligible employees of Lake Havasu Unified School District. This plan, adopted under the provisions of Section 125 of the Internal Revenue Service Code, allows employees to reduce their income in exchange for paying health care expenses, premiums and other expenses with pre-tax dollars which may reduce an employee's potential Social Security benefits. To decline contact Cheri Tropple cheri.tropple@lhusd.org or 928.505.6930.

Premium Deduction Errors

It is your responsibility to verify that the premium deductions taken from your earnings are correct. Any deduction errors must be reported immediately to Human Resources.

Entry Error/Delay

If a data entry error occurs or if data entry is delayed, it most likely will not invalidate the coverage. However, the longer the error occurs, the more likely coverage can be jeopardized. We cannot stress enough that you should review all your deductions, and other information, on your payroll check! Upon discovery of an error, an adjustment will be made to reflect the correct premium deduction. If underpayment of a premium occurs, Lake Havasu Unified School District has the right to collect any additional premiums owed by you. If an overpayment occurs, Lake Havasu Unified School District will reimburse you the amount overpaid.

L. I. F. E. Wellness

The NAEBT Wellness Program

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

Goals of L.I.F.E. Wellness

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

NAEBT'S Wellness Benefit - ALL wellness services required by Health Care Reform are covered at 100% for NAEBT medical/Rx benefit plan participants. ***Effective July 1, 2020 the only coverage for off-site preventative screenings are those that are mandated by healthcare reform. All on-site preventive screenings are covered at 100% by NAEBT.***

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

Screenings/Service

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

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

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

Children – Immunizations and newborn screenings

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

For a list of all services and prescription drugs covered by Health Care Reform, please visit the following website: https://www.healthcare.gov/preventive-care-benefits/

On-Site Screenings

As a part of NAEBT's Wellness Program, many preventive screenings are brought on-site to provide participants a convenient and timely way to protect their health. On-site screenings are covered at 100% by NAEBT.

The following screenings are provided on an annual basis:

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

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

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

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

NAEBT 2020-21 Wellness Calendar

July	August	September	October
		Flu & Pneumonia Vaccinations 	Mammography Screenings  Prostate Screenings Cardiac & Organ Screenings 
November	**December**	**January**	**February**
Wellness Survey Comprehensive Eye Screenings  Shingles Education and Vaccinations	Stress Management Program with Chair Massages 	Health Risk Assessment Screenings 	Health Risk Assessment Screenings 
March	**April**	**May**	**June**
Health Risk Assessment Screenings	Colon Cancer Program with Colorectal Kits  Skin Cancer Screenings	Skin Cancer Screenings 	Stress Management Program with Chair Massages 

A variety of wellness challenges & programs will be provided each month to keep you active and well all year long! Watch your wellness emails for more information on specific programming.

*Subject to change. Questions? Email Cheri Tropple at cheri.tropple@lhusd.org

Special Notices

Medicare Notice of Creditable Coverage Reminder

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

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

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema. Plan limits, deductibles, co-payments, and coinsurance apply to these benefits.

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

If you or your children are eligible for Medicaid or CHIP, and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-855-432-7587 or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, and are eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

Exemption from Mental Health & Substance Abuse Use Disorder Parity

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Northwest Arizona Employee Benefit Trust has elected to be

exempt from the following requirement:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefit and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from this Federal requirement will be in effect for the Plan Year beginning July 1, 2020 and ending June 30, 2021. This election is intended to be renewed for subsequent Plan Years.

If you have any questions regarding this election to exempt Northwest Arizona Employee Benefit Trust from the requirements of the Mental Health Parity and Addiction Equity Act, please feel free to contact your Participating Employer.

CONTACT INFORMATION

Claims Administrator:

AmeriBen IEC
AmeriBen processes medical plan claims and can answer questions about eligibility, medical benefits, and network providers.
1.877.635.2909
www.MyAmeriBen.com

Medical Review:

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

Nationwide Provider Network:

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

BlueCare Anywhere:

24/7 Access to healthcare
1.844.606.1612
www.bluecareanywhereaz.com

Prescription Drug Program:

Navitus 1.855.673.6504
www.navitus.com

Employee Assistance Program (EAP):

EAP Preferred 1.800.327.3517 or 1.602.264.4600
www.eappreferred.com
Username: NAEBT
Password: eappreferred

Dental & Vision Coverage:

Ameritas
Dental eligibility, benefits, claims, and ID Cards. 1.800.487.5553

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

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

The Standard Insurance Co.
1.800.447.3146
www.standard.com

Teladoc:

Access to U.S. board-certified doctors & pediatricians 24/7/365.
1.800.362.2667
www.teladoc.com

AmeriFlex:

AmeriFlex administers the FSA and DCA accounts and can be reached by calling 1.888.868.3539 or logging on to www.myameriflex.com.

HSA Bank:

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

ECA, Inc:

ECA serves as the Trust Administrator.
Stephanie Moore 928-753-4700 Ext 303 or stephaniem@ecollinsandassociates.com.