Tuba City

Regional Health Care Corporation

2024 Benefit Summary

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IMPORTANT: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page **34** for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Contact Information

If you have specific questions about a Tuba City Regional Health Care benefit plan, please contact the administrator listed below, or your local Human Resources department.

Benefit	Administrator	Phone	Website/Email
Medical	Ameriben	855.258.2654	www.myameriben.com
Vision			
Flex			
Dental	Delta Dental	800.352.6132	www.deltadentalaz.com/member
Prescriptions	Navitus Health Solutions	866.333.2757	www.navitus.com
PPO Network – In-Arizona*	Blue Cross Blue Shield of Arizona	855.258.2654	www.myameriben.com (online tools/important links)
PPO Network – Out-of-Arizona**	PHCS	866.245.7427	www.multiplan.com/search
Life and Disability	SunLife	800.786.5433	www.sunlife.com
Accident, Critical Illness, and Hospital Indemnity	SunLife	800.786.5433	www.sunlife.com
401(k)	Transamerica	800.755.5801	www.tubacity.trsretire.com
EAP	JBG Personal Care	Tucson: 888.520.5400 Toll Free: 520.575.8623	www.jorgensenbrooks.com
Benefit Advocate Center		888.818.3543	bac.tchealthcso@ajg.com
Online Enrollment	Navigate	N/A	https://ajg.employeenavigator.com/benefits/Account/Login Company identifier: Tuba
Human Resources	Lori Black, Total Rewards Specialist	928.283.2000	lori.black@tchealth.org
	Jill Curley, Sr. Total Rewards Specialist	928.283.2517	jill.curley@tchealth.org

*Blue Cross Blue Shield of Arizona is available only to members **living in** Arizona.

PHCS is available only to members **who live outside of Arizona or residents of Arizona traveling outside of Arizona.

Benefits Overview

Tuba City Regional Healthcare Corporation is proud to offer a comprehensive benefits package to eligible, full-time employees. The complete benefits package is briefly summarized in this booklet.

You share the costs of some benefits (medical and dental), and Tuba City Regional Health Care provides other benefits at no cost to you (life, accidental death & dismemberment, short-term/long-term disability, and employee assistance program). In addition, there are voluntary benefits with reasonable group rates that you can purchase through Tuba City Regional Health Care payroll deductions.

Eligibility

All coverage for new employees begins the first day of the month following the date of full-time hire.

Open Enrollment

The plan year for benefits is January 1 to December 31 each year. During open enrollment you may enroll in or make changes to your benefits. Open enrollment is the only time you may add or change benefits during the year unless you have a "qualifying life event." Please make sure you understand the benefits offered and enroll yourself and your dependents in the programs that you would like for the coming year.

Qualifying Life Event

A qualifying life event allows you to change your medical / dental benefits outside the open enrollment period. Qualifying life events include:

- Marriage
- Divorce
- Legal Separation
- Birth of a Child
- Adoption of Change in Custody
- Death
- Loss of Dependent Coverage (including spousal coverage through employer)

When you experience a qualifying life event you have 30 days to complete and submit a change form to Human Resources.

Medical Benefits Schedule (Grandfathered Plan)

Administered by Ameriben

To find a provider, visit MyAmeriBen.com

Summary of Benefits			
	TCRHCC	Network Providers Blue Cross Blue Shield of Arizona	Non-Network Providers
Annual Benefit Maximum	Unlimited		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total, which may be split between Network and Non-Network providers.			
Annual Deductible (per calendar year)	N/A	$200 single / $600 family	$500 single / $1,500 family
Note: The Network and Non-Network deductibles will apply toward each other. Deductibles will apply toward the out-of-pocket maximum amounts.			
Annual Out-of-Pocket Maximum (includes deductible)	N/A	$1,500 single / $3,000 family	$5,000 single / $15,000 family
Note: The Network and Non-Network out-of-pocket maximums will apply toward each other.			
Copayments Physician Visits Emergency Room Urgent Care	N/A	$20 $300 $30	N/A
Note: Copayments will not apply toward the deductible. Copayments will not apply toward the out-of-pocket maximum amounts.			
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the calendar year unless stated otherwise.			
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.			
» Copayments » TMJ charges » Prescription Drug charges		» Sleep Studies for Sleep Disorders » Growth Hormone charges » Vision Hardware charges	
Doctor's Office			
Office Visits*	100%	100% after $20 copayment, no deductible applies	60% after deductible
Teladoc	Not applicable	100% deductible waived	Not covered
Inpatient Visits (including Urgent Care)	100%	80% after deductible	60% after deductible
Well-Adult Care* (routine exams, x-rays/tests, immunizations/ flu shots, PSA, mammograms, Pap smear and gynecological exam)	100%	100% after $20 copayment, no deductible applies	Not covered
Routine Colonoscopy / Sigmoidoscopy (Including virtual colonoscopies) for covered persons age 50 and over)	100% One exam every five years.	80% after deductible One exam every five years.	60% after deductible One exam every five years.
Well-Child Care* (routine exams, x-rays / tests, immunizations though age 18)	100%	100% after $20 copayment, no deductible applies	Not covered
Surgery	100%	80% after deductible	60% after deductible
Allergy Testing	100%	80% after deductible	60% after deductible
Allergy Serum and Injections	100%	80% after deductible	60% after deductible
Diagnostic Testing (x-ray and lab)	100%	100%, no deductible applies	60% after deductible
Advanced Imaging (MRI, MRA, CT, Nuclear and PET)	100%	80% after deductible	60% after deductible

Medical Benefits Schedule *(continued)*

Summary of Benefits			
	TCRHCC	Network Providers Blue Cross Blue Shield of Arizona	Non-Network Providers
Diagnostic Colonoscopy / Sigmoidoscopy (Including virtual colonoscopies)	100%	80% after deductible	60% after deductible
*The office visit copayment will apply to the office visit and all other office services, including lab and x-rays, performed and billed by the physician for the same date of service.			
Hospital Services			
Ambulance Service	N/A	80% after deductible	80% after deductible
Room and Board	100% the semiprivate room rate	80% after deductible the semiprivate room rate	60% after deductible the semiprivate room rate
Intensive Care Unit	100% Hospital's ICU Charge	80% after deductible Hospital's ICU Charge	60% after deductible Hospital's ICU Charge
Emergency Room Services	100%	100% after $300 copayment, no deductible applies (copayment waived if admitted or if services are a result of a Mental Disorder or Substance Abuse condition)	60% after deductible
Urgent Care	100%	100% after $30 copayment, no deductible applies	60% after deductible
Mental Health Services			
Inpatient Services	N/A	80% after deductible	60% after deductible
Outpatient Services	100%	80% after deductible	60% after deductible
Substance Abuse Services			
Inpatient Services	N/A	80% after deductible	60% after deductible
Outpatient Services	100%	80% after deductible	60% after deductible
Rehabilitation Therapy			
Inpatient Services	100% (no limit)	80% after deductible (45 days per calendar year maximum)	60% after deductible (45 days per calendar year maximum)
Outpatient Services	100% (no limit)	100% after $20 copayment, no deductible applies (45 days per calendar year maximum)	60% after deductible (45 days per calendar year maximum)
Other Services			
Physical, Occupational and Speech Therapy Services (16 visits per calendar year)	100%	100% after $20 copayment, no deductible applies	60% after deductible
Durable Medical Equipment	N/A	80% after deductible	60% after deductible
Prosthetics	100%	80% after deductible	60% after deductible
Orthotics	100%	80% after deductible	60% after deductible
Chiropractic and Spinal Manipulation (16 visits per calendar year)	N/A	100% after $20 copayment, no deductible applies	60% after deductible

Medical Benefits Schedule *(continued)*

Summary of Benefits			
	TCRHCC	Network Providers Blue Cross Blue Shield of Arizona	Non-Network Providers
TMJ and Related Services	100%	80% after deductible	60% after deductible
Skilled Nursing Facility	N/A	80% after deductible the facility's semiprivate room rate (62 days calendar year maximum)	60% after deductible the facility's semiprivate room rate (62 days calendar year maximum)
Home Infusion Therapy	N/A	80% after deductible	60% after deductible
Home Healthcare	N/A	80% after deductible (130 visits per calendar year)	60% after deductible (130 visits per calendar year)
Hospice Care	N/A	80% after deductible	60% after deductible
Acupuncture	N/A	80% after deductible (16 visits per calendar year)	60% after deductible (16 visits per calendar year)
Diabetes Education	100%	80% after deductible	60% after deductible
Hearing Exam	100%	100% after $20 copayment, no deductible applies	60% after deductible
Sleep Studies for Sleep Disorders	N/A	80% after deductible	60% after deductible
Organ Transplants	N/A	80% after deductible	60% after deductible
Maternity Services	100%	80% after deductible	60% after deductible
Routine Well-Newborn Care	100%	80% after deductible	60% after deductible
Adoption	N/A	50% after deductible $3,500 per adoption	50% after deductible $3,500 per adoption
Infertility Benefits (includes care, supplies and services for diagnosis and treatment of infertility. In vitro fertilization is excluded.)	100%	50% after deductible	50% after deductible`
All Other Covered Services	100%	80% after deductible	60% after deductible

Prescription Benefits

Administered by Navitus Health Solutions

	TCRHCC	Network Provider
Copayment Maximum (Once the copayment has been met, the plan will pay 100% of prescription drug expenses for the rest of the calendar year)	$0 copay	$3,500
Retail—Generic Drug (30-day copayment)		$5 or 20%, whichever is greater
Retail—Formulary Drug (30-day copayment)		$10 or 30%, whichever is greater
Retail—Non-Formulary Drug (30-day copayment)		$25 or 50%, whichever is greater
Mail Order—Generic Drug (90-day supply)	N/A	$10
Mail Order—Formulary Drug (90-day supply)	N/A	$30
Mail Order—Non-Formulary Drug (90-day supply)	N/A	$50

Where to Submit Retail Pharmacy Claims

Navitus Health Solutions is the Retail Pharmacy Prescription Claims Administrator. Claims for expenses should be submitted to Navitus Health Solutions, at the address below:

Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999

Customer Service Telephone Number: **866.333.2757**
www.navitus.com

Where to Submit Mail Order Pharmacy Claims

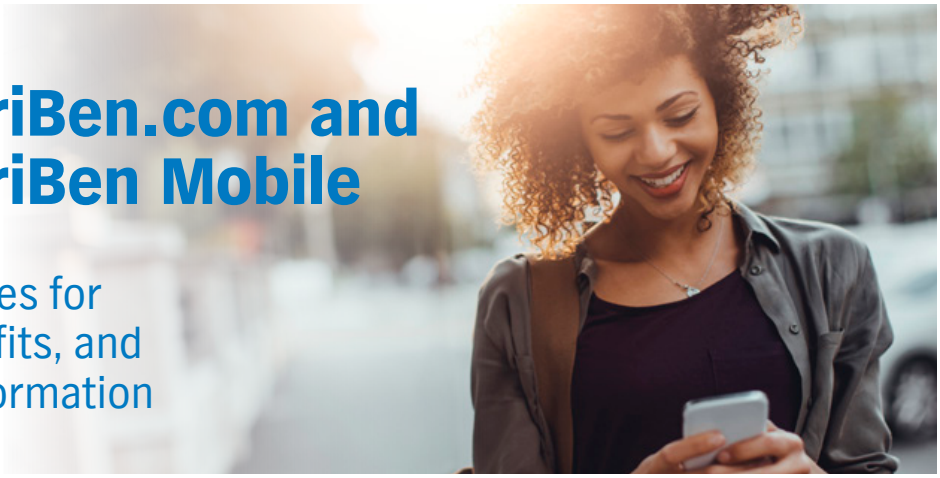
Navitus Health Solutions is the Mail Order Prescription Claims Administrator. Claims for expenses should be submitted to Navitus Health Solutions at the address below:

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999

Customer Service Telephone Number: **866.333.2757**

MyAmeriBen

MyAmeriBen.com and MyAmeriBen Mobile



Your resources for claims, benefits, and eligibility information

Register your account today.

To register online:

1. Visit www.MyAmeriBen.com
2. If you are a first-time user, select the **Click here to register** button.
3. Complete all fields on the registration page. Be sure to enter your full legal name. If you enter a nickname, your information will not match the information in the database, and you will not be able to register.
4. Create a secure password that is at least eight characters long and contains at least one special character (!@#$&*).
5. Choose **Submit** and accept the *Terms and Conditions* that will appear.

To register on MyAmeriBen Mobile:

1. Download MyAmeriBen Mobile on your iOS or Android device. Download on the App Store GET IT ON Google Play
2. Open the app.
3. If you have previously logged in to MyAmeriBen.com, use the same username and password for MyAmeriBen Mobile. If you have not previously created a user profile, select **Create an Account** on the homepage and follow the instructions.
4. Read and accept the licensing agreement.
5. Confirm your identity.

Claims status

Check the status of your medical claims 24/7. View general summaries and detailed reports.

Digital ID card

Never lose your card again. It's easy to download and send straight to providers.

Online support

Chat with our online support specialists in real time or submit a question to be answered via email within two business days.

Benefit information

Access general plan information including your plan document, benefit information, and provider networks.

Document upload

Use your smartphone's camera to instantly upload claims documents.

If you need help registering or have questions, please call Customer Service at **855-258-2654**

AmeriBen

Tuba City Regional Health Care Corporation

Vision Benefits

Included in Medical Plan

If an employee elects the medical plan, they are automatically enrolled in the vision plan. Vision is not a stand-alone product. Employees may visit any provider for this benefit.

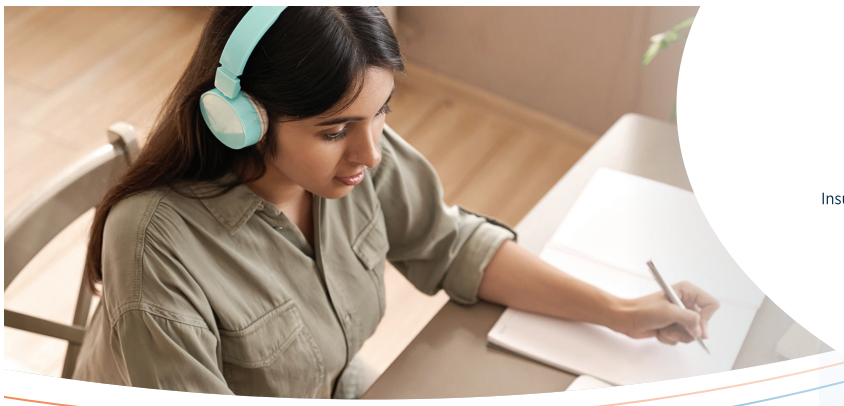
	In-Network
Eye Exam – once per calendar year	100% after $20 copayment, no deductible applies. (Copayment required for services rendered outside of TCRHCC.)
Lenses, Contact Lenses, and Frames – once per calendar year	Lump sum up to $200 annually, no deductible applies.

If your provider will not seek payment from Ameriben, please mail itemized receipts along with your name, address, and group number to the following address:

Ameriben—Claims
P.O. Box 7186
Boise, ID 83707

Or fax it to:
Attn: Claims
208.424.0595

Medical/RX/Vision				
Enrollment	Employee Monthly Cost	Employee Biweekly Cost	TCRHCC's Monthly Cost	Total Monthly Cost
Full-Time Employee				
Single Coverage	$74.55	$37.28	$406.78	$481.33
2-Party Coverage	$159.60	$79.80	$828.10	$987.70
Family Coverage	$204.75	$102.38	$1,115.25	$1,320.00
Part-Time Employee				
Single Coverage	$148.05	$74.03	$333.28	$481.33
2-Party Coverage	$323.40	$161.70	$664.30	$987.70
Family Coverage	$402.15	$201.08	$917.85	$1,320.00



Gallagher

Insurance | Risk Management | Consulting

Ask Your Advocate Team

Put our team to work to maximize your healthcare benefits.

Gallagher is ready to help you get the most from your benefit program by providing support from an advocate at no cost to you. Get assistance with:

1. **Explanation of benefits**
   Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
2. **Prescription challenges**
   Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization for a medication?
3. **Benefits questions**
   Are you unsure if the insurance company will pay for a certain procedure?
4. **Claim issues**
   Did you receive a bill from a doctor but don't know why?
5. **Difficult situations**
   Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

A licensed healthcare benefits advocate is ready to handle any situation in a discreet and confidential manner.

Hours of operation

Monday – Friday

7 a.m. – 8 p.m. Central Time

Connect With Us

Tuba City Health

888.818.3543

bac.tchealthcso@ajg.com

ajg.com **The Gallagher Way.** Since 1927.

TELADOC®

Tuba City Regional Health Care Corporation

Talk to a doctor anytime

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- **Cold & flu symptoms**
- **Allergies**
- **Sinus problems**
- **Sore Throat**
- **Respiratory infection**
- **Skin problems**
- **And more!**

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary physician it is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short term prescription refills

Talk to a doctor anytime for **free!**

Teladoc.com

1-800-Teladoc (835-2362)

Available on the iPhone App Store

ANDROID APP ON Google play

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Dental Benefits

Administered by Delta Dental of Arizona

Find a Network Dentist: deltadentalaz.com/find

This plan has entered into an agreement with certain dental care providers, which are called participating providers.

These participating providers of Delta Dental have agreed to charge reduced fees to persons covered under the plan.

Therefore, when a covered person uses a dental participating provider, that covered person will most likely pay less out-of-pocket than when seeing a nonparticipating provider (i.e., no PPO discount will be given and the covered person will be responsible for any amount billed over the Usual & Reasonable Charge). It is the covered person's choice as to which dental provider to use.

Delta Dental			Non Delta Dental Dentist[1]
	PPO Dentist	Premier Dentist[1]	
Annual Maximum (Combination of in and out-of-network)	$2,000		$1,500
Lifetime Orthodontia Maximum (Combination of in and out-of-network)	$2,000		$1,500
Annual Deductible (Individual / Family) (Combination of in and out-of-network)	$50 / $100		$50 / $100
Preventive Services			
• Exams, evaluations or consultations: Two in a benefit year. • 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. • 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. • Space Maintainers: For missing posterior primary (baby) teeth up to age 19. • Emergency (Palliative Treatment): Treatment for the relief of pain.	100%		100%
Basic Services			
• Sealants: For children up to age 19 - Once in a 3-year period for permanent molars and bicuspids. • Fillings: Silver amalgam and for front teeth only, synthetic tooth color fillings. One per surface every two years. • Stainless Steel Crowns • Endodontics: Root canal treatment (permanent teeth). Pulpotomy primary (baby) teeth. • Oral Surgery: Simple extractions. • Oral Surgery: Surgical extractions. • Bridge and Denture Repair: Repair of such appliances to their original condition, including relining of dentures. • Restoration of Inlays and Onlays.	90%[2]		80%[2]
Major Services (Waiting period 6 months)*			
• Periodontics: Treatment of gum disease - Non-surgical once every two years. Surgical once every three years. • Prosthodontics: Bridges, partial dentures, complete dentures - 5-year waiting period for replacement last performed. • Implants: Implants are only a benefit to replace a single missing tooth bounded by teeth on each side. Limited to $1000 per tooth, per lifetime and is applied to the patient's annual maximum benefit. • Restorative: Crowns, Inlays and onlays - 5-year waiting period for replacement last performed.	60%[2]		50%[2]
Orthodontic Services			
• Benefit for adults and children age 8 and older. 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.	60%		50%

[1]Members may incur higher out-of-pocket costs when seeing a Premier or Non Delta Dental dentist. See below.

[2]Deductible applies to these services.

*Waiting Period applies only if member did not have prior dental coverage.

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

Dependent Age Limit: 26 | Predetermination recommended for services over $250.

Tuba City Regional Health Care Corporation's plan is a Delta Dental PPO plus Premier plan. You and your family members may visit any licensed dentist. There are three levels to choose from:

- PPO Dentist—Payment is based on the PPO dentist's allowable fee or the actual fee charged, whichever is less.
- Premier Dentist—Payment is based on the Premier Maximum Reimbursable Amount (MRA), filed fee, or the fee actually charged, whichever is less.
- Non Delta Dental Dentist—Payment is based on the Premier Maximum Reimbursable Amount (MRA), Members are responsible for the difference between the Premier Maximum Reimbursable Amount (MRA) and the full fee charged by the dentist.

To Find A Dentist – **www.deltadentalaz.com** Customer Service: **800.352.6132**

Dental				
Enrollment	**Employee Monthly Cost**	**Employee's Biweekly Cost**	**TCRHCC's Monthly Cost**	**Total Monthly Cost**
Full-Time Employee				
Single Coverage	$15.00	$7.50	$35.00	$50.00
2-Party Coverage	$25.00	$12.50	$50.00	$75.00
Family Coverage	$40.00	$20.00	$60.00	$100.00
Part-Time Employee				
Single Coverage	$21.00	$10.50	$29.00	$50.00
2-Party Coverage	$35.00	$17.50	$40.00	$75.00
Family Coverage	$56.00	$28.00	$44.00	$100.00

Flexible Spending Accounts (FSA)

Administered by Ameriben

FSAs provide you with an important tax advantage that can help you pay healthcare and dependent care expenses on a pretax basis. By anticipating your family's healthcare and dependent care costs for the next year, you can actually lower your taxable income.

You have the opportunity to pay for childcare expenses, insurance deductibles, and other medical/dental expenses from your pretax income up to $8,050 per year. You may choose to participate in the pretax premium contribution, Healthcare expense plan, and the Dependent Care expense plan or all three.

You are allowed to carryover unused Healthcare Flexible Spending Account funds at the end of each Plan Year, up to, but not exceeding the maximum amount allowed by the IRS for the applicable plan year. For 2024, the maximum allowed amount is $610. The carryover provision replaces the previous grace period provision and is for healthcare expenses only.

This benefit has three tiers:

1. **Premium Expense Account**—allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer to you. These premium expenses include: Healthcare and dental care premiums.
2. **Healthcare Reimbursement**—enables you to pay for qualified expenses, which are not covered by your medical plans and save taxes at the same time. This account allows you to be reimbursed by the Employer for your out-of-pocket medical, dental, vision expenses incurred by you and your dependents. You may contribute up to $3,050 per plan year.
3. **Dependent Care Assistance Account**—You may contribute up to $5,000 (per family) to cover eligible dependent care expenses ($2,500 if you and your spouse file separate tax returns).

The 125 Flexible Benefit program is an annual plan. The policy year is January 1, 2024 to December 31, 2024. At the beginning of each year of participation you **must re-enroll**.

Monthly Employee Contributions

	Without Flexible Spending	With Flexible Spending
Gross Income	$20,000	$20,000
Pretax Expenses for Health / Dependent Care	$0	$2,550
Taxable Income	$20,000	$17,450
Less Taxes, FICA	$4,600	$3,839
After-Tax Expenses for Health / Dependent Care	$2,550	$0
Spendable Income	$12,850	$13,611
Your Savings with Flexible Spending	$0	$761

The Flexible Spending Account election date is January 1 each year. If you are not currently participating, please consider enrolling.

What is Not Eligible

For additional information, visit **www.irs.gov/publications/p502/index.html**.

Healthcare expenses that do not qualify as a federal income tax deduction under IRS Code Section 213 do not qualify for payment through your spending account. The following list includes many of the common expenses that generally do not qualify for reimbursement.

These expenses may be eligible if they are prescribed by a physician (If medically necessary for a specific condition).

Personal Hygiene (i.e., deodorant, soap, body powder, shaving cream, sanitary products, etc.)
Breast Pump (if for convenience)
Cosmetic Surgery
Cosmetics (i.e., makeup, lipstick, cotton swabs, cotton balls, baby oil)
Counseling (i.e., marriage and family counseling)
Denture care (i.e., denture cleansers and denture adhesive creams)
Dental care—Routine (i.e., toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, breath strips, teeth whitening/bleaching, etc.)
Diapers
Exercise Equipment
Hair Care (i.e., hair color, shampoo, conditioner, brushes, hair loss products)
Health Club or Fitness Program Fees
Homeopathic Supplements or Herbs
Household or Domestic Help
Laser hair removal
Massage Therapy
Maternity Clothes
Nail care and personal grooming (i.e., scissors, nail files)
Nutritional and dietary supplements (i.e., bars, milkshakes, power drinks, Pedialyte)
Skin Care (i.e., sun block, moisturizing lotion, lip balm)
Sleep aids (i.e., oral medications, snoring strips)
Vitamins
Weight reduction aids (i.e., Slimfast, appetite suppressants)

Healthcare Expense Account—Sample Expenses

Medical Expenses

Acupuncture
Addiction Programs and Products
Adoption (Medical expenses for baby birth)
Alternative Healer Fees
Allergy Relief (Oral Medications, Nasal Spray)
Ambulance
Antacids and Heartburn Relief
Arthritis Pain Relieving Creams
Anti-itch and Hydrocortisone Creams
Artificial Limbs
Athlete's Foot Treatment
Body Scans
Care for Mentally Handicapped
Chiropractor
Cold Medicines (i.e., Syrups, Drops, Tablets)
Contraceptives
Copayments
Crutches
Diabetes (i.e., Insulin, Glucose Monitor)
Eye Patches
Fertility Treatment
Fever & Pain Reducers (i.e., Aspirin, Tylenol)
First Aid (i.e., Bandages, Gauze, Creams)
Hearing Aids & Batteries
Hypnosis (For Treatment of Illness
Incontinence Products (i.e., Depends, Serene)
Joint Support Bandages and Hosiery
Lab Fees
Laxatives
Monitoring Device (Blood Pressure, Cholesterol)
Motion Sickness Medication
Physical Exams
Pregnancy Tests
Prescription Drugs
Psychiatrist/Psychologist (for mental illness)
Physical Therapy
Smoking Cessation Relief (i.e., Patches, Gum)
Speech Therapy
Stomach & Digestive Relief (i.e., Pepto-Bismol, Imodium, etc.)
Tooth and Mouth Pain Relief (Orajel, Anbesol)
Urinary Pain Relief
Vaccinations
Vaporizers or Humidifiers
Wart Removal Medication
Weight Loss Program Fees (with doctor's note)
Wheelchair

Dental Expenses

Artificial Teeth
Copayments
Deductible
Dental Work
Dentures
Orthodontia Expenses
Preventive Care at Dentist Office (Bridges, Crowns, etc.)

Vision Expenses

Braille—Books & Magazines
Contact Lenses
Contact Lens Solutions
Eye Exams
Eye Glasses
Laser Surgery
Office Fees
Guide Dog and its upkeep or other animal aid

How do you want to pay for your out-of-pocket health care expenses?

With dollars that haven't been taxed?

Or with dollars that have been taxed?

The average family of four in the U. S. can expect to pay almost $3,300 a year on out-of-pocket medical expenses.

Out-Of-Pocket Expenses	Annual Average	Taxes Saved (27% tax bracket)*
Physician	$1,030	$278
Inpatient Hospital	$1,045	$282
Pharmacy	$560	$151
Outpatient Hospital	$525	$142
Other	$120	$32
TOTAL:	$3,280	$885

If that $3,280 were put into a Health Care FSA, the family could save over $885 in taxes.

Out-of-pocket expenses through member cost sharing at time of service.
Per Milliman Medical Index 2011, published May 2011.

For additional information, go to

Learn more during your open enrollment!

*The amount you save in taxes with a Flexible Spending Account will vary depending on the amount you set aside in the account; your annual earnings; whether or not you pay Social Security taxes; the number of exemptions and deductions you claim on your tax return; your tax bracket and your state and local tax regulations. Check with your tax advisor for information on how participation will affect your tax savings.

This brochure highlights some of the benefits of the Benny® Prepaid Benefits Card. If there is a discrepancy between this material and your official plan document, the plan document will govern. Evolution1 reserves the right to amend or modify the services at any time.

EC-071 081511

Isn't It Time To Save On Your Health Care Expenses?

Sign up for a Flexible Spending Account and save all year long!

And, get the Benny® Prepaid Benefits Card to make it easy.

Uncle Sam Wants to Help You!

Did you know that you can deduct medical expenses from your federal tax return? But, only 8% of U.S. taxpayers have enough medical expenses to qualify. That means 92% get NO tax benefit.

However, there is a tax-saving benefit that 100% of employees **can** enroll in – a Flexible Spending Account! You can sign up for an FSA and set aside tax-free funds for your out-of-pocket medical expenses. With an FSA, your health care contribution amount is deducted from your paycheck each pay period, in equal installments throughout the year – before federal, Social Security, and (in most cases) state income taxes are taken out. So, every dollar you put in an FSA means **more tax-free, spendable income.**

The easy way to pay is in the Cards.

Having a Health Care Flexible Spending Account (FSA) is a good idea. The Benny® Prepaid Benefits Card makes it fast and convenient to access the money you've set aside in your FSA. Benny contains the value of your annual health care FSA election amount, and you can use Benny to pay for qualified medical expenses not covered by your health insurance. Benny automatically deducts the cost of your eligible expenses from your FSA. Just swipe and go. It's that easy!

Now that you know that FSAs are a smart move, see how The Benny Prepaid Benefits Card makes it easy!

And how do you get your Benny?

Look for details during open enrollment, or ask your Human Resources representative for more information.

Benny® helps you save time, money and paperwork!

Using Benny helps keep cash in your wallet. You'll never "pay twice" – first from your paycheck into your FSA and then again at the time of purchase. You'll have no claim forms to complete, and you won't have to wait to get a check in the mail. You can check balances or account details online anytime or with a quick phone call.

And, there are tens of thousands of merchant locations where you can use the Card for the purchase of eligible prescription out-of-pocket and eligible over-the-counter (OTC) expenses, and you won't have to routinely submit receipts to verify the purchase. But, it's always a good idea to save your receipts for easy reference, and the IRS may require them.

You can use the Card to pay for:

- Prescription and health plan copayments, deductibles and coinsurance
- "Amount Due" on medical and dental statements
- Orthodontics
- Mail-order or online prescription invoices
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items** such as:
  - First Aid Dressings and Supplies – bandages, rubbing alcohol
  - Contact Lens Solutions/Supplies
  - Diagnostic Products like thermometers, blood pressure monitors, cholesterol testing
  - Insulin and Diabetic Testing Supplies

** The list of eligible OTC items has changed per the Patient Protection and Affordable Care Act of 2010. Contact your Plan Administrator for more information.

Life and Accidental Death & Dismemberment Insurance

Insured by SunLife

Group Life Benefit—Paid 100% by TCRHCC

Summary of Benefits		
Benefits	Employee	Spouse and Dependent
Life Benefit		
Amount	200% of annual salary rounded to the next higher $1,000	$5,000 Spouse $5,000 Child
Minimum Amount	$50,000	
Maximum Amount	$1,000,000	
AD&D Benefit		
Amount	200% of annual salary rounded to the next higher $1,000	
Minimum Amount	$50,000	
Maximum Amount	$1,000,000	
Benefit Reduction		
Benefits will reduce:	At age 65 your coverage will reduce by 35% of the original amount. At age 70 your coverage will reduce by 60% of the original amount. At age 75 your coverage will reduce by 75% of the original amount.	
Eligibility		
	You qualify if you are an active full or part-time employee working at least 30 hours a week. You must be working in an eligible group as defined by your employer. If you are a new hire or have not been previously covered by your employer's plan, you may need to complete a probationary or waiting period of 30 days before your coverage begins.	

Short-Term and Long-Term Disability Benefits

Administered by SunLife

Short-Term Disability—Paid 100% by TCRHCC

Summary of Benefits	
Short-Term Disability is intended to protect your income for a SHORT DURATION in case you become ill or injured.	
Eligibility	You qualify if you are an active full-time employee working **at least 30 hours a week**. If you are a new hire or have not been previously covered by your employer's plan, you will need to complete a probationary or waiting period of **30** days of employment.
Maximum Monthly Benefit	60% of salary up to $3,500 per week.
Maximum Benefit Duration	13 weeks
Elimination Period	Benefits begin on: 14th day for an injury 14th day for an illness
Benefit Reductions	Your benefit may be reduced if: » Your disability results from an intentional self-inflicted injury; or you became injured while committing a criminal act or while driving under the influence of alcohol/drugs. » You are not under the regular care of a doctor when requesting disability benefits. » Your disability is covered under a workers' compensation plan and/or is due to a job-related illness or injury. » Please refer to your policy documents for a complete list of income sources that will reduce your benefits, as well as a complete list of exclusions and limitations.

*Be advised of the following offsets to the STD benefit:

» PTO does not offset and SunLife does not require the employee's to exhaust before being eligible for STD.
» Salary Continuation will only offset for the amount over 100% of the employee's pre-disability earnings.
» Sick Leave is a direct offset.

Long-Term Disability—Paid 100% by TCRHCC

Summary of Benefits	
Long-Term Disability is intended to protect your income for a LONG DURATION after you have depleted short-term disability or any sick leave your company may offer.	
Eligibility	All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date.
Maximum Monthly Benefit	50% of salary up to $20,000, amount will vary based on job title.*
Maximum Benefit Duration	Five Years from the date of disability.
Elimination Period	90 days The number of days you must be disabled prior to collecting disability benefits.
Benefit Reductions	You will not receive benefits under certain circumstances. Examples include: » Your disability results from an intentional self-inflicted injury; or you became injured while committing a criminal act or driving under the influence of alcohol/drugs. » You are not under the regular care of a doctor when requesting disability benefits. » You are receiving payment under a salary continuance or retirement plan sponsored by your employer.
Preexisting Condition	Preexisting Conditions may affect the benefits paid by your Long-Term Disability policy: • A preexisting condition is an illness, injury or pregnancy-related condition for which you were diagnosed, received medical treatment, or prescribed medications during the 3 month period before your coverage effective date. • No benefit will be paid during the first 12 consecutive months after your coverage effective date for a disability related to a preexisting condition. • Benefits will be paid for covered disabilities not related to a preexisting condition. • Please refer to your policy documents for a complete list of income sources that will reduce your benefits, as well as a complete list of exclusions and limitations.

*Class 1 and 2-$20,000 per month max; Class 3-$15,000 per month max

For assistance or additional information

Contact SunLife at **800.786.5433** or log on to **www.sunlife.com**.

Note: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Paid Time Off

Time off benefit information is located on the intranet. http://intranet.tchealth.org/index.html

(**Credentialed Staff** begin leave benefits at the max hours per pay period 7.6923 year level)

Maximums are based on Full-time service (2080 hrs. per year).

Years of Service	0 – 3 years	4 – 9 years	10 – 14 years	15 years +
Months of Service	*0 – 36 months*	*37 – 119 months*	*120 – 170 months*	*180 months +*
Max days per year:	20 days	25 days	30 days	35 days
Max hours per year:	160 hours	200 hours	240 hours	280 hours
Max hours per pay period:	6.1538 hours	7.6923 hours	9.2307 hours	10.7692 hours
Max per-hour accrual:	0.0769 hours	0.0961 hours	0.1153 hours	0.1346 hours

Other leave benefits related to: Leave Benefits

- Bereavement Leave
- Educational Leave
- Jury Duty
- Military Leave

Supersedes date: 18 June 2009

- Religious Holidays/Ceremonies
- Voting Leave
- LWOP

Voluntary Life Benefit

	Summary of Benefits		
Benefits	Employee	Spouse	Dependent
Life Benefit			
Amount	Increments of **$10,000** up to a maximum of **$500,000** (not to exceed **7X** your salary)	Increments of **$5,000** up to a maximum of **$250,000**	$10,000
Minimum Amount	$10,000	$5,000	$10,000
Maximum Amount	$500,000	$250,000	$10,000
Guaranteed Issue *Applies to new hires only	$250,000	$50,000	$10,000
AD&D Benefit			
Amount	Equal to Optional Life Insurance. You must buy optional life coverage to be eligible to buy optional AD&D coverage.	Equal to Optional Life Insurance	Equal to Optional Life Insurance
Benefit Reduction			
Benefits will reduce:	At age 65 your coverage will reduce by 35% of the original amount. At age 70 your coverage will reduce by 60% of the original amount. At age 75 your coverage will reduce by 75% of the original amount.		

Rate Table for Voluntary Life Benefit (rate per $1,000)

Age	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Employee	0.035	0.035	0.035	0.045	0.053	0.089	0.140	0.220	0.323	0.549	1.090	1.090	1.090
Spouse	0.035	0.035	0.035	0.045	0.053	0.089	0.140	0.220	0.323	0.549	1.090	1.090	1.090

Child(ren): $1.45 per $10,000 of coverage

Rate Table for Voluntary AD&D Benefit:

Employee	$0.020 per $1,000 of coverage
Spouse	$0.020 per $1,000 of coverage
Child(ren)	$0.020 per $1,000 of coverage

Group Accident Insurance Coverage

Sponsored by Tuba City Regional Healthcare Corporation

Insured bySunLife

Accident insurance coverage provides a cash benefit when an insured is injured due to a covered accident. An accidental injury can be costly, especially if you are financially unprepared. Your current medical coverage will help pay for expenses associated with an injury, but won't cover all of the out-of-pocket expenses you may face. Don't wait until you are rushed to the emergency room to realize you need more protection

Eligibility: All employees in an eligible class. Issue Ages 17-80.

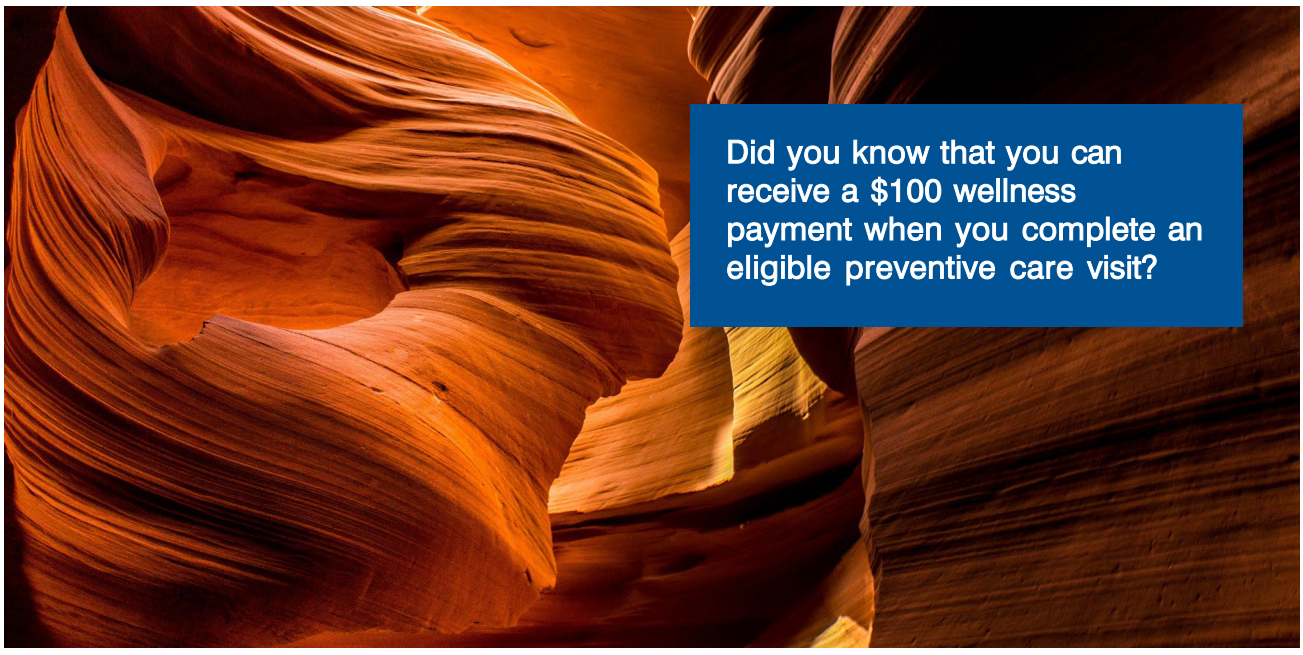
LIFE AND DISMEMBERMENT LOSSES*	Benefit Amount	
Accidental Death $50,000	$50,000	
Accidental Death Common Carrier (pays an additional benefit if accidental death occurs while traveling as a fare-paying passenger on a public conveyance)	$200,000	
Catastrophic Loss: Both arms or both hands, both legs or both feet, one hand and one foot or one arm and one leg, or irrecoverable loss of sight of both eyes	$25,000	
Loss of one hand, foot, leg, or arm	$15,000	
Loss of sight of one eye or loss of one eye	$25,000	
Two or more fingers or toes	$3,000	
One finger or one toe	$1,500	
Loss of hearing of one ear or loss of one ear	$5,000	
DISLOCATIONS	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip	$8,000	$4,000
Knee, ankle, or bones of the foot	$3,000	$1,500
Elbow, wrist, Shoulder, Collarbone, bones of the hand or Lower jaw	$2,000	$1,000
Finger(s) or toe(s)	$400	$200
FRACTURES OPEN	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip, thigh or Skull-simple $8,000 $4,000	$8,000	$4,000
Skull-depressed $7,500 $3,750	$7,500	$3,750
Vertebral processes, Bones of the face, Nose, Upper jaw, upper arm, Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow, Heel or Multiple ribs	$1,500	$750
Leg $3,000 $1,500	$3,000	$1,500
Vertebrae, Sternum or Pelvis	$2,400	$1,200
Rib, Finger, Toe or Coccyx	$600	$300
ADDITIONAL INJURIES		
Eye Injury - surgical repair $300	$300	
Eye Injury - object remove $300	$300	
Brain injury $500	$500	
Paralysis—paraplegia $20,000	$20,000	
Paralysis—quadriplegia $50,000	$50,000	
Coma $20,000	$20,000	
Concussion $200	$200	
BURNS	**2ND DEGREE**	**3RD DEGREE**
20-40 square centimeters $300 $750	$300	$750
41-65 square centimeters $600 $1,500	$600	$1,500
66-160 square centimeters $800 $4,500	$800	$4,500
161-225 square centimeters $1,200 $10,000	$1,200	$10,000
More than 225 square centimeters $1,500 $15,000	$1,500	$15,000
Skin graft 50% of the applicable Burn Benefit	50% of the applicable Burn Benefit	
LACERATIONS		
No sutures and treated by doctor $35	$35	
Single laceration under 5 cm with sutures $65	$65	
5-15 cm with sutures (total of all lacerations) $250	$250	
Greater than 15 cm with sutures (total of all lacerations) $700	$700	
MEDICAL SERVICES		
Diagnostic Exam - Arteriogram, Angiogram, CT, CAT, EKG, EEG, or MRI (1 time per benefit year)	$100	
Diagnostic Exam - X-ray (1 time per covered accident)	$200	
Accident Emergency Treatment, non-emergency room (once per covered accident)	$250	
Physician's Follow-up Treatment office visit (per visit, up to 6 times per covered accident)	$100	
Physical Therapy (per visit up to 10 visits per covered accident)	$75	
Medical Devices	$300	
Epidural Pain Management (up to 2 times per covered accident)	$100	
Prescription drug	$35	
Prosthesis (one)	$1,000	
Prosthesis (two)	$2,000	
Anesthesia	$100	
Blood, Plasma, or Platelet Transfusion	$500	

*Benefits displayed for life and dismemberment are for the employee only. Spouse benefits are 100% of the employee benefit amount for death and 100% of the employee benefit amount for dismemberment. Dependent children benefits are 50% of the employee benefit amount for death and 50% of the employee benefit amount for dismemberment.

HOSPITAL	Benefit Amount
Hospital Admission (once per benefit year) $1,500	$1,500
Hospital Confinement (per day up to 365 days per covered accident) $200	$200
Intensive Care Unit Admission (once per Benefit Year; payable instead of Hospital Admission benefit if Confined immediately to ICU)	$2,000
Intensive Care Unit Confinement (per day up to 14 days, payable in addition to any Hospital Confinement benefit)	$400
Ambulance (Ground)	$200
Ambulance (Air)	$750
Emergency Room Admission	$300
Family Lodging (per day up to 30 days per benefit year)	$200
Transportation (100 or more miles up to 3 times per covered accident)	$1,000
Rehabilitation Unit (per day up to 30 days per covered accident)	$200
SURGERY	
Miscellaneous Surgery requiring general anesthesia (not covered by any other benefit)	$750
Open Surgery	$2,000
Exploratory Surgery or Debridement	$500
Tendon/Ligament/Rotator Cuff Tear	$1,000
Torn Knee Cartilage	$1,000
Ruptured/Herniated Disc	$1,000
EMERGENCY DENTAL	
Emergency Dental extraction	$65
Emergency Dental crown	$200

Accident Rates: Biweekly (deducted every pay period)

Employee	$5.76
Employee + Spouse	$8.77
Employee + Children	$13.38
Family	$16.38



Group Critical Illness Insurance Coverage

Sponsored by Tuba City Regional Healthcare Corporation

Insured by SunLife

Critical Illness insurance coverage provides a cash benefit to the policyholder when an insured person has a covered illness event.

Eligibility: All employees in an eligible class. Issue Ages 17-70.

Critical Illness Base Coverage			
Initial Critical Illness Benefits	Option 1	Option 2	Option 3
Heart Attack (100%)	$10,000	$20,000	$30,000
Stroke (100%)	$10,000	$20,000	$30,000
Coronary Artery Bypass Surgery (25%)	$2,500	$5,000	$7,500
Major Organ Transplant (100%)	$10,000	$20,000	$30,000
End Stage Renal Failure (100%)	$10,000	$20,000	$30,000
Cancer Critical Illness Benefits			
Invasive Cancer (100%)	$10,000	$20,000	$30,000
Carcinoma in Situ (25%)	$2,500	$5,000	$7,500
Additional Benefits			
Second Event Initial Critical Illness Benefit	Yes	Yes	Yes
Wellness Benefit (per year)	$100	$100	$100
Additional Features			
Continuation of Insurance Coverage to Age 70	Yes	Yes	Yes

Spouse and Child(ren) benefit is limited to 50% of the employee benefit amount.

Cost Summary

Employee premiums are based on employee actual age. Spouse premiums are based on employee's actual age.

Employee Non-Tobacco rates by age						
Coverage amounts	<31	31-39	40-49	50-59	60-69	70+
$10,000	$3.60	$6.10	$11.30	$19.50	$31.60	$40.70
$20,000	$7.20	$12.20	$22.60	$39.00	$63.20	$81.40
$30,000	$10.80	$18.30	$33.90	$58.50	$94.80	$122.10

Spouse Non-Tobacco rates by age						
Coverage amounts	<31	31-39	40-49	50-59	60-69	70+
$10,000	$1.80	$3.05	$5.65	$9.75	$15.80	$20.35
$20,000	$3.60	$6.10	$11.30	$19.50	$31.60	$40.70
$30,000	$5.40	$9.15	$16.95	$29.25	$47.40	$61.05

Employee Tobacco rates by age						
Coverage amounts	<31	31-39	40-49	50-59	60-69	70+
$10,000	$5.30	$9.80	$20.40	$34.00	$55.80	$72.90
$20,000	$10.60	$19.60	$40.80	$68.00	$111.60	$145.80
$30,000	$15.90	$29.40	$61.20	$102.00	$167.40	$218.70

Spouse Tobacco rates by age						
Coverage amounts	<31	31-39	40-49	50-59	60-69	70+
$10,000	$2.65	$4.90	$10.20	$17.00	$27.90	$36.45
$20,000	$5.30	$9.80	$20.40	$34.00	$55.80	$72.90
$30,000	$7.95	$14.70	$30.60	$51.00	$83.70	$109.35

Child Rates	
Coverage amounts	
$5,000	$0.10
$10,000	$0.20
$15,000	$0.30

Group Hospital Indemnity Coverage

Sponsored by Tuba City Regional Healthcare Corporation Insured by SunLife

Hospital Indemnity insurance coverage provides a cash benefit to the policyholder when an insured person has a covered hospital stay.

Eligibility: All employees in an eligible class. Issue Ages 17-70.

Hospital Indemnity Base Coverage	
First Day Benefits – Payable per benefit year	
First day hospital confinement This benefit pays the first day you stay in a regular hospital bed.	$1,500
Confinement Benefits – Payable per benefit year	
Hospital Confinement This benefit pays for a hospital stay in a standard room Payable with: - First day hospital confinement benefit	$150 per day Up to 30 days
Intensive Care Unit (ICU) confinement This benefit pays for a hospital stay in the ICU. Payable with: -First day hospital confinement benefit - Hospital confinement benefit	~~$10,000~~ ~~XXXXX~~ $300 per day; up to 10 days

Hospital Indemnity Rates: Biweekly (deducted every pay period)

Employee	$15.00
Employee + Spouse	$22.15
Employee + Children	$20.31
Family	$32.08

Employee Assistance Program

Confidential, free help for personal, family and work problems.

Our Employee Assistance Program has one purpose – to work closely with you to correct situations before they interfere with your home or work life. We do this with high quality clinical and personal care. **JBG Clinical Care** is described on this page; **JBG Personal Care** on the next.

JBG CLINICAL CARE

What types of problems are covered by JBG Clinical Care?

Confidential assessment and brief counseling for:

- Marital Relationship
- Parent / Child Conflicts
- Grief and Loss
- Anxiety
- Stress
- Depression
- Substance Abuse
- Workplace Issues
- Gambling
- Other Concerns

How do I contact JBG Clinical Care and what should I expect?

Call Jorgensen Brooks Group at **520.575.8623** (toll free, **888.520.5400**). Local, in-person clinical appointments can be made Monday through Friday, 8:00am through 4:30pm. Telephone and Internet Chat clinical appointments (45 minutes with licensed therapists) are offered, Monday through Saturday, 5:00am through 6:00pm. Crisis services are available 24 hours/7 days.

How many counseling sessions do I get and how many times can I use JBG Clinical Care?

You and your family can have **up to six (6) sessions per person**, per year. If you experience additional problems within the year, another series of **up to six (6) free sessions** may be authorized. Sessions for marital/relationship and family/child problems are for the group involved. A 90 day break between problems is required. Adult children living in the household may receive services up until the age of 26.

What if I need services beyond JBG Clinical Care?

JBG Clinical Care can guide you to available options, including self-help groups; behavioral health professionals; treatment programs; or other resource based on your condition, financial needs and/or insurance coverage. Always, **JBG Clinical Care** will first refer you to network providers in your medical plan. Once referred, you will be responsible for the cost of these services.

Call – 24 hours/7 days
Tucson: 520.575.8623
Toll Free: 888.520.5400

Confidential Services!
Your employer is not told who uses JBG Clinical Care or JBG Personal Care.

JBG PERSONAL CARE

JBG Personal Care is another important benefit of your Employee Assistance Program. With this free, confidential service, professional consultants help you solve non-clinical problems for which you may not have experience or resources. Without the support of **JBG Personal Care**, life's pressures can become over-whelming.

Examples of key [not all] JBG Personal Care services are:

- **Legal:** Will preparation, landlord disputes, separation and divorce, estate issues; services can include 30 minute free consultation, in-person or by telephone with a local attorney, and a 25% discount on attorney fees. Employee disputes with employers are not covered.
- **Financial:** Budgeting, managing credit card debt, other matters. Financial planning is a regulated service and not included.
- **ID theft recovery:** Assistance with prompt notification of creditors and other financial providers; guidance on managing a return to control of your identity.
- **Child and Elder care:** Appropriate providers are nearby specialty resources for infants, children and older citizens
- **Education:** Resources for all types - primary and private, non-profit and profit, trade and higher education.
- **Housing:** Resources for all types – temporary and permanent, self-paying or subsidized.
- **Savings Center:** Discounts on thousands of personal, home and business goods without a membership fee.
- **Medical advice:** Website information provided through the **Mayo Clinic**.

You and your family have ***free, unlimited use of JBG Personal Care***; the services are ***available 24 hours/7 days by telephone, internet chat, or website***.

Call – 24 hours/7 days
Tucson: **520.575.8623**
Toll Free: **888.520.5400**

JBG Personal Care Website

- **www.jorgensenbrooks.com**
- Home page; Click JBG Personal Care
- Find and click on "Click here to access your JBG Personal Care;" in the new window, type in your Company Login: **"JBG"**

Live Chat

- Follow instructions to JBG Personal Care
- Home page, upper left
- Click on LIVE CONNECT
- Complete brief inquiry form to connect to Chat Now.

Confidential Services!
Your employer is not told who uses JBG Clinical Care or JBG Personal Care.

Important Notices and Disclosures

Women's Health and Cancer Rights Act

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

» All stages of reconstruction of the breast on which the mastectomy has been performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance;

» Prostheses; and

» Treatment of physical complications of all stages of mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please contact Human Resources.

HIPAA Special Enrollment Rights

Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Tuba City plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid. georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/ benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/ applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075

PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2023 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully.

The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with health care benefits. This notice describes the plans' health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information' (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information about You

The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf.

For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures descried in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the plans by third-party administrators known as "business associates." For example, the plans may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special Use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Worker's Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker's compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and coy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Change to this Notice

The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI

You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and nay of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at the Employer, Attention: Privacy Officer.

Updated and effective March 26, 2019

Grandfathered Plan Disclosure

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at **https://www.tchealth.org/benefits.html**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Prescription Drug Coverage and Medicare

Date of this Notice: January 2024

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Tuba City has determined that the prescription drug coverage offered by Tuba City is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Tuba City coverage will be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your Tuba City prescription drug coverage, be aware that you may not be able to get this coverage back.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In addition, your current coverage pays other health expenses in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

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

You should also know that if you drop or lose your current coverage with Tuba City and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare and You handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

DCN24BGTC