Lake Havasu Unified School District #1

Open Enrollment Guide

For plan year July 1, 2019 – June 30, 2020

Elections you make during open enrollment will become effective July 1, 2019.

This booklet contains important information regarding your benefits for the plan year beginning July 1, 2019. 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 10, 2019. If you do not enroll before the deadline, you will not have Medical/Rx, Dental and/or Vision insurance as of July 01, 2019.

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.

If you have any questions about your benefits, please contact Jaime Schulenberg from ECA at 928.753.4700 x302 or jaimes@ecollinsandassociates.com.

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Contact Information:

The following companies (vendors) provide the services noted to the Trust. Should you need assistance, feel free to contact them at the phone number of website listed.

Medical Claims Administrator:

Gilsbar will continue to be the Medical Claims Administrator. They can be contacted at 1.888.472.4352 or by visiting www.myGilsbar.com.

Arizona Provider Network:

Blue Cross Blue Shield of Arizona will continue to be the Arizona provider network. A list of providers can be found by calling Gilsbar at 1.888.472.4352 or by visiting www.myGilsbar.com or www.azblue.com/chsnetwork.

Prescription Benefit Plan:

CVS/Carmark through NationalCooperative Rx will continue to be the prescription benefit manager. For more information, call 866.818.6911 or visit www.caremark.com.

Dental Coverage:

Ameritas will continue to offer dental coverage. You can find in-network dental providers by calling 1.800.487.5553.

Vision:

Spectera through United Health Care will continue to provide vision coverage. To locate a provider, go to http://myuhcvision.com.

Medical Review (Pre-Certification/Case Management):

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.

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

Gilsbar will continue to administer the Flexible Spending Accounts (FSA) and Dependent Day Care Accounts (DDC). See page 17 of this guide for additional information. Gilsbar can be reached by calling 1.888.472.4352 or by visiting www.myGilsbar.com.

Group Life, Voluntary Life, and AD&D:

Guardian Life will continue to offer Basic Life, Voluntary Life and Accidental Death & Dismemberment benefits. You may contact Guardian at 1.800.525.4542 if you have any questions.

Short-Term Disability:

Guardian Life will continue to provide voluntary Short-Term Disability benefits. You may contact Guardian at 1.800.268.2525 for questions.

Medical Coverage and Benefit Eligibility:

Please review the enclosed materials for detailed explanations of the plans available to you and your family. All full-time employees are eligible for benefits.

Benefit Enrollment:

Open enrollment will be from April 22, 2019 through 5:00PM on May 10, 2019 for changes effective July 01, 2019.

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 Qualifying Life Event* as outlined below:

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

You MUST request enrollment via the portal within 31 days of the Life Event.

*For a full list of qualifying events, please refer to your Summary Plan Document.

General Medical Plan Information:

What's New for 2019-20?

The following changes were implemented January 01, 2019:

Medical/Rx

- Reduce Office Co-Pay from $55 to $25 Primary Care Physician / $50 Specialist;
- Reduce Free-Standing Lab and X-Ray from Deductible+CoInsurance to a $50 Co-Pay (NOTE: Advanced Imaging [i.e., CT Scans, MRIs, PET Scans, etc.] remain subject to Deductible+CoInsurance, as does use of a hospital for lab and x-ray services.);
- Provide Male Sterilization with No Member Cost Share;
- Add Telemedicine through Teladoc with No Member Cost Share; and
- Reduce Rx Co-Pay for 90-Day Retail and Mail Prescriptions from $25/$105/$195 to $20/$70/$130.

In addition, the following changes will be implemented July 01, 2019:

Medical/Rx

- Reduce Deductible from $2,500 / $5,000 to $750/$1,500;
- Reduce Maximum Out-of-Pocket from $6,500 / $13,000 to
  - $4,000 / $8,000 Medical **+**
  - $3,900 / $7,800 Rx
    (This means that prescription co-payments will apply to the separate maximum out-of-pocket noted; once that limit has been met, eligible prescriptions would be paid at 100%.)
- Eliminate Case Management Penalty; and
- Add a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)
  - $4,000 / $8,000 Deductible and Maximum Out-of-Pocket
  - Once members reach the deductible/maximum out-of-pocket, eligible expenses will be paid at 100%.
  - An HSA is a savings vehicle that can be used to pay for eligible expenses; unlike an FSA, monies in this account roll over from year to year, belong to you and are portable.
  - **The District will contribute $320.76 annually to your Health Savings Account if you elect coverage under the HDHP.**

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 for a covered prescription drug expense at the time the service/prescription is received.

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 $2,500, then you must pay the first $2,500 of covered medical costs subject to deductible before the plan will pay.

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 $8,000, of a $10,000 facility bill, and the participant is responsible for the remaining 20%, or $2,000, up to the maximum out-of-pocket amount.

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

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 Gilsbar, LLC, at 1.888.472.4352, or log on to www.myGilsbar.com. Be sure to verify eligibility and plan benefits before a charge is incurred.

Pre-Certification Requirements

American Health Group (AHG) must be notified for all non-emergency hospital admissions at least 48 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 will 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 is a voluntary program whereby a Case Manager monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. If you have any questions regarding case management, contact American Health Group (AHG): 1.800.847.7605 or 1.602.265.3800.

Gilsbar

Gilsbar, LLC is located in Covington, Louisiana, and serves as the third-party administrator (TPA) for LHSEBT. Duties of the TPA include verification of eligibility and claims payments, among other functions.

LHSEBT is a "self-funded" plan, which means they assume the financial risk for providing healthcare 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. Self-funded plans hire a variety of subcontractors (vendors) to administer the various pieces of the Plan, such as the TPA, medical network, etc.

After you visit the doctor, in-network providers send the claim to BlueCross BlueShield of AZ (BCBSAZ) for repricing. BCBSAZ discounts the service based on the agreement they have with that provider. Once repriced, it is sent to Gilsbar for processing and payment. Gilsbar compares the billing codes to the Summary Plan Document to verify the charges are for eligible services. If approved, it is processed for payment. The provider will receive a check and the member 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 an EOB from Gilsbar, you should call Gilsbar at 1.888.472.4352 to inquire if they have received the claim or you can contact your provider to verify they have your correct insurance billing information. If the services rendered aren't eligible for coverage under the Plan, Gilsbar will send a denial to the provider in the form of an EOB which is copied to the member. This EOB outlines the reason the charges aren't eligible for payment and provide information on how to appeal if the provider and/or member believes the services should be covered.

Non-network providers send their claims directly to Gilsbar for processing or payment. If it is a large claim (over $5,000), Gilsbar 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 Member.

National CooperativeRx/CVS Caremark

National CooperativeRx is a national, not-for-profit purchasing cooperative. They contract with CVS/Caremark to provide pharmacy benefits to LHSEBT members.

For specific information regarding the prescription plan, including coverage and co-pay information, visit the Caremark website at http://www.caremark.com or contact a CVS Caremark Customer Care representative at 800.552.8159.

Exclusive Provider Organization (EPO)

Outline of Benefits

MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
Plan-Year Deductible per Member Per Family	$750 $1,500	N/A N/A
Out-of-Pocket Medical Maximum per Member Per Family	$4,000 $8,000 (Includes Deductible)	Unlimited Unlimited (Includes Deductible)
Out-of-Pocket Rx Maximum per Member Per Family	$3,900 $7,800	Unlimited Unlimited
Inpatient Hospital	20% After Deductible	Not Covered
Outpatient Facility	20% After Deductible	Not Covered
Office Visits Physician's Office	 $25 Co-Pay/PCP $50 Co-Pay/Specialist	 Not Covered
Urgent Care Facility	$55 Co-Pay	Not Covered
Preventive Services* (as mandated by federal law)	0% No Deductible	Not Covered
Chiropractic Care (limited to 30 visits)	$100 Co-Pay	Not Covered

Diagnostic Testing, X-Ray and Lab Services Freestanding Facility Hospital	 $50 Co-Pay 20% After Deductible	 Not Covered Not Covered
Advanced Imaging (CT Scans, MRIs, PET Scans, etc.)	20% After Deductible	Not Covered
Maternity	20% After Deductible	Not Covered
Emergency Room Non-Emergency Medical Condition	$200 Co-Pay + 20% After Deductible Not Covered	$200 Co-Pay + 20% After Deductible Not Covered
Mental Health & Substance Abuse Inpatient	20% After Deductible	Not Covered
Mental Health & Substance Abuse Outpatient	$25 Co-Pay	Not Covered

*NOTE: Routine/Preventive Mammograms are available throughout the year from Mobile On-Site Mammography (MOM) with no member cost share. Mammograms performed at locations other than MOM and without a letter of necessity from your physician will be subject to deductible and co-insurance.

Prescription Plan

Outline of Benefits

30-day supply at a Retail Pharmacy	
• Prescribed preventive medication as required by federal law	$0 Co-Pay
• Generic Drugs	$10 Co-Pay
• Preferred Drug*	$35 Co-Pay
• Non-Preferred Drug*	$65 Co-Pay
90-day supply at a Retail Pharmacy or Mail Order	
• Prescribed preventive medication as required by federal law	$0 copay
• Generic Drugs	$20 Co-Pay
• Preferred Drug*	$70 Co-Pay
• Non-Preferred Drug*	$130 Co-Pay
Specialty	20% to Max of $300

Brand Name Penalty: If your physician authorizes the use of a Generic drug but you choose to use a Brand Name drug, you must pay the difference between the actual cost of the Generic and Brand in addition to the Brand Name co-payment.

High Deductible Health Plan (HDHP)

Outline of Benefits

MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
Plan-Year Deductible per Member	$4,000	N/A
Per Family	$8,000	N/A
Out-of-Pocket Medical/Rx Maximum per Member	$4,000	Unlimited
Per Family	$8,000 (Includes Deductible)	Unlimited (Includes Deductible)
Inpatient Hospital	20% After Deductible	Not Covered
Outpatient Facility	20% After Deductible	Not Covered

Office Visits Physician's Office	$0 After Deductible	Not Covered
Urgent Care Facility	$0 After Deductible	Not Covered
Preventive Services* (as mandated by federal law)	0% No Deductible	Not Covered
Chiropractic Care (limited to 30 visits)	$0 After Deductible	Not Covered
Diagnostic Testing, X-Ray and Lab Services	$0 After Deductible	Not Covered
Maternity	$0 After Deductible	Not Covered
Emergency Room Non-Emergency Medical Condition	$0 After Deductible Not Covered	$0 After Deductible Not Covered
Mental Health & Substance Abuse Inpatient	$0 After Deductible	Not Covered
Mental Health & Substance Abuse Outpatient	$0 After Deductible	Not Covered
Prescriptions	$0 After Deductible	Not Covered

2019/20 Rates

Medical/Rx – Gold Plan

	Monthly Premium	Employer Contribution		Employee Contribution	
		24 Pays	18 Pays	24 Pays	18 Pays
Employee Only	$719.42	$359.71	$479.61	$0	$0
Employee+Spouse	$1,245.54	$393.15	$524.20	$229.62	$306.16
Employee+1 Child	$1,116.77	$463.17	$617.55	$95.22	$126.96
Employee + Children	$1,402.69	$534.51	$712.68	$166.84	$222.45
Employee+Family	$1,823.20	$602.10	$802.80	$309.50	$412.66

Medical/Rx – High Deductible Health Plan*

	Monthly Premium	Employer Contribution 24 Pays	18 Pays	Employee Contribution 24 Pays	18 Pays
Employee Only	$692.69	$346.35	$461.79	$0	$0
Employee+Spouse	$1,196.90	$379.79	$506.38	$218.67	$291.55
Employee+1 Child	$1,073.53	$449.80	$599.73	$86.97	$115.95
Employee + Children	$1,345.94	$521.15	$694.86	$151.83	$202.43
Employee+Family	$1,750.24	$588.74	$784.98	$286.38	$381.84

NOTE: The District will contribute $320.76 annually (in increments based on your elected pay schedule) to a Health Savings Account (HSA) for those employees who enroll in the HDHP.

Dental

	Monthly Premium	Employer Contribution 24 Pays	18 Pays	Employee Contribution 24 Pays	18 Pays
Employee Only	$27.00	$13.50	$18.00	$0	$0
Employee+Spouse	$56.00	$13.50	$18.00	$14.50	$19.33
Employee+1 Child	$47.00	$13.50	$18.00	$10.00	$13.33
Employee + Children	$73.00	$13.50	$18.00	$23.00	$30.67
Employee+Family	$102.00	$13.50	$18.00	$37.50	$50.00

Vision

	Monthly Premium	Employer Contribution 24 Pays	18 Pays	Employee Contribution 24 Pays	18 Pays
Employee Only	$5.18	$2.59	$3.45	$0	$0
Employee+Spouse	$10.35	$2.59	$3.45	$2.59	$3.45
Employee+1 Child	$9.41	$2.59	$3.45	$2.12	$2.82
Employee + Children	$9.41	$2.59	$3.45	$2.12	$2.82
Employee+Family	$16.94	$2.59	$3.45	$5.88	$7.84

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 LHSEBT's FSA will allow you to pay less in taxes and keep more of your hard-earned money. The 2018 maximum contribution amount is $2,650. The FSA is an annual election and **MUST be** elected annually via the Benefit Enrollment/Change Form. FSA's are pre-funded, which means that the total amount of your election will be available to you on July 1st. 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.

Gilsbar administers FSA accounts and can be reached by calling 1.888.472.4352 or logging on to www.MyGilsbar.com.

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 or filing separate. The DDC is an annual election and **MUST** be elected annually via the Benefit Enrollment/Change Form 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.

Gilsbar administers DDC accounts and can be reached by calling 1.888.472.4354 or logging on to www.MyGilsbar.com.

Tax-Free Savings for Medical Expenses (HSA)

Health Savings Account (HSA)

An HSA is an individual savings account that can be used to pay for qualified medical expenses. This account is available in conjunction with a high deductible health plan (HDHP). 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 expenses and as long as you use the money for a qualified medical expense, your funds are NEVER taxed! The maximum contribution amounts for 2019 are $3,500 for single coverage and $7,000 for family coverage. Employees age 55 and older can make an additional $1,000 catch-up contribution. Please see the attached flyers for additional information regarding HSA's.

Gilsbar will administer the HSA in conjunction with Healthcare Bank.

Dental Benefits

There are no changes to the Dental Plan offered through Ameritas.

Benefit Type	In-Network Providers	Out-of-Network Providers
Type 1 Preventive	0%	30%*
Type 2 Basic	20% / 10%* / 0%*	40%*
Type 3 Major	50%*	60%*
Periodontal Coverage	20%*	40%*
Endodontics	20%*	20%*
Annual Deductible (Single/Family)	$50 / $150	
Type 1 Waiting Period	None	
Type 2 Waiting Period	6 Months (Newly Enrolled)	
Type 3 Waiting Period	12 Months (Newly Enrolled)	
Orthodontia	$1,000 Lifetime Max	Not Covered
Ortho Waiting Period	12 Months (Newly Enrolled)	N/A

*Subject to Deductible

Vision Benefits

There are no changes to the Vision plan offered through Spectera (aka United Healthcare).

Benefit Frequency	
Comprehensive Exam(s)	Once Every 12 Months
Spectacle Lenses	
Frames	
Contact Lenses in Lieu of Eyeglasses	
In-Network Services	
Co-Pays	
Exam(s)	$10
Materials	$10
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to this overage)	
Private Practice Provider	$100 Retail Frame Allowance
Retail Chain Provider	
Lens Options	
Standard Scratch-Resistant Coating, Polycarbonate Lenses for Dependents – Covered in Full Other optional lens upgrades may be offered at a discount (discount varies by provider)	
Contact Lens Benefit (Selection contact lenses refers to our formulary contract list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at myuhcvision.com.)	
Selection Contact Lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after co-pay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-Selection Contact Lenses An allowance is applied toward the purchase of contact lenses outside of the selection. Materials co-pay (if applicable) is waived.	$105.00
Necessary Contact Lenses	Covered in full after co-pay (if applicable)

Basic Life Insurance/AD&D

Basic Life Insurance

Basic life Insurance will continue to be administered by Guardian. Each employee will be provided 150% of your annual salary up to $150,000 in life insurance and Accidental Death & Dismemberment (AD&D), spouses enrolled in Medical/Rx will be provided $5,000 in life insurance and each eligible child enrolled in Medical/Rx will be provided $2,500 in life insurance.

Voluntary Life Insurance

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. A legal spouse can also be covered from $5,000 to $250,000 in increments of $5,000. Children can be covered from $2,000 to $10,000 in increments of $2,000. You must complete the applicable forms when electing this benefit available from Payroll. Some coverage may be subject to medical underwriting.

Additional Benefits

AFLAC

AFLAC offers a variety of plans including Personal Accident, Personal Cancer and Hospital. Premiums are paid in full by the employee via payroll deduction. For more information or to enroll, contact Jack Freyn at 928.208.6827.

403b Plan

The 403b Plan provides employees with an opportunity to save for retirement. For more information or to enroll, contact Payroll.

Special Notices

Medicare Part D Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with LHSEBT 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are four important things you need to know about the 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. LHSEBT has determined that the prescription drug coverage offered under the Gold Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

3. Prescription drug coverage offered under the HDHP Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, coverage is considered **Non-Creditable Coverage**. <u>This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have the prescription drug coverage through LHSEBT. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.</u>

When Can You Join a Medicare Drug Program?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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 LHSEBT and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 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.

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 coverage will not be affected. Your current medical coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare drug plan, you will still be eligible to receive medical and prescription drug benefits through LHSEBT. If you do enroll in a Medicare drug plan, in general, the following guidelines apply:

- If you are an active employee, or the covered dependent of an active employee, you are required to obtain your outpatient prescription drug benefits through your LHSEBT plan first. You can then file on a secondary basis with your Medicare drug plan.

- If you are a COBRA participant, or the covered dependent of a COBRA participant, you are required to obtain your outpatient prescription drugs through your Medicare drug plan first. Secondary coverage is not available through LHSEBT.

Important: You can only waive prescription drug coverage by waiving the entire LHSEBT medical/prescription plan coverage for yourself and your dependents. Remember, if you do waive your coverage, active employees can only re-enroll in the medical/prescription combined plan during the next Open Enrollment Period.

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

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

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

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

- Visit www.medicare.gov/
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 800.772.1213 (TTY 800.325.0778).

Name of Entity/Sender:	Lake Havasu Unified School District #1 Employee Benefit Trust
Contact Person:	Cheri Tropple, Benefits & Payroll Specialist
Address:	2200 Havasupai Boulevard Lake Havasu City, AZ 86403
Phone Number:	928.505.6930

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, copayments, and coinsurance apply to these benefits.

Newborns' and Mother's Health Protection Act Notice

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, (including medical plans sponsored by the City) generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefit or out-of-pocket costs so that nay later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your plan provider to pre-certify the extended stay. If you have questions about this Notice, contact Gilsbar at 888.472.4352.

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 1-855-432-7587or 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).

Privacy Notice Reminder

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in a health Plan and receive your Summary Plan Document. You can get another copy of this Notice from Payroll by calling 928.505.6930.