City of Tempe

2024-2025 BENEFITS PLAN YEAR OPEN ENROLLMENT

WHAT'S NEW FOR THE 2024-2025 PLAN YEAR?

This year you will see a slight increase to medical and dental rates. This results in a 4.9% increase to Mediflex contributions.

Health Flexible Spending Account (FSA)
Remember you must re-enroll on an annual basis! Unused Medical contributions up to **$640** can be rolled over for the next plan year. Re-enrollment in the Healthcare Reimbursement Account is REQUIRED for any rollover contributions. Minimum contribution of $130 annually is required.

DON'T FORGET

This year is a PASSIVE enrollment for medical, dental and vision. You must re-enroll in Flexible Spending Account (FSA) and complete the waiver request form to waive the City's medical plan.

Check Your Dependents
You must immediately provide written notification and documentation to HR in the event of legal separation, divorce or removal of Domestic Partner and applicable children.

Opt out Credit
If you are a full-time or part-time benefitted employee and you wish to opt out of the medical insurance coverage, you will still need to participate in this year's open enrollment process **and** complete the Medical Insurance Waiver Request form to receive the opt-out ($100) stipend.

Recuro Health- $10 Copay
Just a reminder for those who participate on the medical plans you have – 24/7/365 access to board-certified primary-care doctors, pediatricians and urgent care by secure video, phone or e-mail for treatment for: Allergies, Asthma, Bronchitis, Cold & Flu, Sinus, Earaches, and more!

Optavise
Did you know your Optavise Advocate can give you cost and quality information for a procedure or test BEFORE you have it? Please see page 15 of the Benefits Guide for more information.

Wellness
If you accumulated 100 points between May 1, 2024, and April 30, 2025, then you have qualified for a $25 per paycheck reduction in your health premium for this upcoming benefits plan year.

If you earn 100 points between May 1, 2024, and April 30, 2025, then you will qualify for a $25 per paycheck reduction in your health premium for this upcoming benefits plan year – July 1, 2024, thru June 30, 2025! You can earn 200 points to receive a $100 gift card!

HOW DO I MAKE CHANGES DURING OPEN ENROLLMENT?

HOW DO I MAKE CHANGES DURING OPEN ENROLLMENT?

Open enrollment begins May 6th & ends May 24th

Open enrollment is provided online through PeopleSoft Self-Service and can be performed using a work or home computer. To access PeopleSoft Self-Service from home, please go to myhr.tempe.gov

From the **Employee Self-Service** home page, select the **Benefits Open Enrollment** tile OR from the main menu by opening the Navigator and **select Self-Service > Benefits > Benefits Open Enrollment.**

Online open enrollment is easy, safe, and confidential. Go online to make changes to your 2024-2025 Medical, Dental, and Vision plans, add/drop/change dependents, or enroll in Flexible Spending Accounts.

If you don't have access to a computer at home or in your work area, computers are available in Human Resources.

Get more information about the benefit plans before you make any decisions by thoroughly reviewing the Benefits Guide with your family. If you have any questions about the City's benefits, call HR Benefits at ***480-350-8700.*** Elections and changes made during Open Enrollment will be effective **July 1, 2024.**

Remember to click on the **submit** button to complete your elections once you are finished with online enrollment. You will be able to print a confirmation statement identifying your elections.

VERY IMPORTANT INFORMATION!

After the Open Enrollment period ends, you cannot make changes to your benefit elections unless you experience a mid-year change in status qualifying event.

DEPENDENT COVERAGE

You can add, drop or change dependents during open enrollment. *(Please note you will need to provide dependent verification to HR Benefits for new dependents.)*

For the medical, dental & vision plans, your eligible dependents may include: (*Dependent children are eligible for coverage through the end of the month of their 26th birthday*).

- Lawful spouse;
- Qualified Domestic Partner;
- Natural Children;
- Stepchildren;
- Legally adopted children and children for whom you/your spouse are a court-appointed legal guardian;
- Children specified under a Qualified Medical Support Order (QMCSO).

If you elect to cover one or more eligible dependents, you must provide documentation to the City that verifies they are eligible for coverage. Applicable documentation includes; a marriage certificate and/or tax statement; birth certificate; adoption agreement; affidavit of domestic partnership; or a QMCSO.

You must immediately provide written notification and documentation to HR in the event of legal separation, divorce or removal of Domestic Partner and applicable children. Enrolling or maintaining ineligible dependents on any of the City's Healthcare plans is a violation of City policy.

Also, you must provide your dependents' social security numbers (SSN). Legislation requires that the City file participant information with the Department of Health and Human Services (HHS). In addition, the centers of Medicare and Medicaid Services (CMS) will use SSN's to identify Medicare-eligible individuals and improve coordination of benefits between Medicare and Group Health Plans. No other entities will be provided with this information.

WHAT HAPPENS IF I HAVE MID-YEAR LIFE CHANGING EVENT?

Because of the tax advantages of plans that let you pay for your benefits with before-tax dollars, the IRS has certain rules about when you can make changes to your benefits. In most cases, you may only make changes during open enrollment. However, you may make changes during the rest of the year if you experience a qualified status change – an event that causes you or a covered dependent to gain or lose eligibility for coverage.

The following are examples of qualifying events:

- You get married, separated, or divorced
- You or your partner establish domestic partner status
- You have a baby or adopt a child
- You or your spouse/domestic partner gain or lose eligibility under an employer plan
- You or your spouse/domestic partner take an unpaid leave of absence
- A dependent starts or stops being eligible

You must notify the Plan in writing within 30 days of the mid-year change in status by contacting HR Benefits. The plan will determine if your change request is permitted and if so, changes become effective on the first day of the month following the date of the event if the application for coverage is timely received (except for newborn and adopted children who are covered back to the date of birth, adoption, or placement for adoption). Documentation, including birth certificate and social security number, marriage certificate, loss of coverage, or proof of no longer residing in the United States must be submitted to the Plan within thirty (30) days of notification. Failure to provide documentation within the timeframe will result in termination of the dependent's coverage.

IF YOU HAVE A CHANGE IN STATUS (INCLUDING THE BIRTH OR ADOPTION OF A CHILD) YOU MUST SUBMIT A CHANGE/ENROLLMENT FORM TO HUMAN RESOURCES WITHIN 30 CALENDAR DAYS OF THE STATUS CHANGE!

You will also need to provide proof of the qualifying event, such as:

- A copy of a marriage license
- A copy of divorce decree
- A copy of birth/adoption certificate
- A letter from your spouse's employer
- A COBRA letter verifying your coverage end date

The coverage change you make must be on account of, and correspond with, your change in status. For example, if you marry during the year, you may add your new spouse to your coverage or enroll in an FSA.

Tempe
ARIZONA

City of Tempe 2024

BENEFITS GUIDE

MEDICAL | DENTAL | VISION | FLEXIBLE SPENDING ACCOUNTS | LIFE & AD&D | DISABILITY | VOLUNTARY LIFE | EAP | WELLNESS | HEALTH ADVOCATE

Welcome to the City of Tempe®, the official sponsor of your benefits program! As an active employee, you are eligible to participate in a competitive benefits program. Benefits are effective July 1, 2024.

The intent of this summary is to highlight your benefits and NOT replace your insurance contracts or booklets. The information has been compiled into a summary form to outline the benefits offered by the City of Tempe.

If this benefits summary does not address your specific benefit questions, please refer to the Customer Service Contact page of this booklet. This page will provide you with the information you need to contact the specific insurance carriers and/or your Human Resources Department for additional assistance.

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract.

The information in this booklet is proprietary. Please do not copy or distribute to others.

Brown & Brown

Created by Brown & Brown for the City of Tempe.

Table of Contents

Customer Service Contact Information

Refer to this list when you need to contact one of your benefit vendors

Benefit	Phone Number	Information	Website
MEDICAL			
CIGNA/Allegiance	1-800-259-2296	Claims, coverage questions, eligibility verification, ID cards	askallegiance.com
Live Well Solutions	1-866-220-3138	24/7 Nurse Line	
Recuro Health	1-855-673-2876	24/7/365 access to Doctors via video, phone or e-mail	recurohealth.com
Allegiance Care Management	1-800-342-6510	Pre-Certification	
Allegiance Maternity Care Management Program	1-877-792-7827	See page 16	
PRESCRIPTION DRUG			
Express Scripts	1-800-711-0917	Member services for PPO pharmacy benefit questions Mail Order	express-scripts.com
EMPLOYEE ASSISTANCE PROGRAM			
CuraLinc SupportLinc	1-888-881-5462	Guidance for everyday issues	supportlinc.com Group code: cityoftempe
CASE MANAGEMENT PROGRAM			
Allegiance Care Management	1-877-792-7827	Case Management Services	askallegiance.com
HEALTH ADVOCATE			
Optavise	1-866-253-2273	Assist with claims issues, research procedure costs, benefit questions	tempe.optavisemember.com advocate@optavise.com
DENTAL			
CIGNA (Dental)	1-800-CIGNA24 (244-6224)	Request listing of CIGNA dentists, dental questions, change dentist selection, eligibility verification	CIGNA.com / myCIGNA.com myCigna Mobile App available through: • Apple App Store • Android Google Play • Amazon Apps • BlackBerry World

Customer Service Contact Information Cont.

Refer to this list when you need to contact one of your benefit vendors

VISION			
Avesis	1-800-828-9341	Customer Service, search for a participating provider	avesis.com
HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)			
Allegiance	1-877-424-3570	Account balance, covered expenses, reimbursement forms, on-line claim submission	askallegiance.com
COBRA SERVICES			
Allegiance	1-800-259-2738	COBRA Administration letter & payment coupons to come from Allegiance after enrollment	askallegiance.com
DEFERRED COMPENSATION			
Nationwide Retirement Services	1-877-652-5115 602-430-2771	Check account balance, fund performance, transfer existing funds or redirect the investment of future contributions, loan information Nancy Feilbach	tempedcp.com nancy.feilbach@nationwide.com
BENEFIT OFFICE			
Benefits Customer Service	480-350-8700	Information on City of Tempe benefits	tempe.sharepoint.com/sites/HumanResources

Welcome to 2024-2025 Benefits at the City of Tempe

The City of Tempe recognizes that employee benefits are one of the most important and valued elements of compensation. That's why we offer a comprehensive benefits package designed to address the Healthcare and financial protection needs of both you and your family. The City of Tempe is proud to provide:

- **Healthcare Programs –** medical, prescription drug, dental and vision benefits for you and your dependents
- **Health Advocate Program –** offering assistance to find a doctor, answer benefit questions, assist with claims issues and research procedure costs
- **Income Protection Plans –** group term life insurance and accidental death and dismemberment insurance
- **Money-Saving Opportunities –** pre-tax flexible spending accounts that give you a tax break on dollars you spend for health and/or dependent care and depending on years of service, an employer-funded account called *"Mediflex"* for reimbursement of eligible medical expenses

In addition, the City of Tempe offers a variety of benefits and programs that can help you plan for the future. This Benefits Guide contains the plan information you need to know to make informed benefit decisions, so please take a few moments to review it thoroughly.

Whether you're going through Open Enrollment or starting employment with City of Tempe as a new employee, you will be asked to select the benefits of your choice and enroll in a City-sponsored plan. This Benefits Guide will prove to be an invaluable tool that will help you make the best choices for you and your family.

Healthy Me In Tempe - Wellness Program Information

Healthy Me In Tempe, can help you achieve your well-being goals and be the best you. The Healthy Me In Tempe platform can be customized to match your goals. If you earn 100 points between May 1, 2024, and April 30, 2025, then you will qualify for a $25 per paycheck reduction in your health premium for this upcoming benefits plan year – July 1, 2024, through June 30, 2025! You can earn 200 points to receive a $100 gift card!

WHY WELLNESS MATTERS

Over 50% of our medical plan expenses are lifestyle related. If we each can improve on lifestyle and try and break some of those unhealthy habits, our own health and well-being is strengthened. The City's wellness initiative will also help to slow health plan cost. Tempe is ahead of the curve in the type of wellness program we have implemented over the past few years, and we want to continue offering incentives and programs that encourage you to exercise, eat better, stop unhealthy habits, and improve your health.

NEW IDEAS?

The Wellness Program is overseen by the Employee Wellness Committee. Please share your ideas on improvements or program additions with your Committee.

To OPT OUT from the City's Medical Plan

If you are a full-time or part-time benefit eligible employee and you wish to opt out of the health insurance coverage offered by the City, you will have a $100(FTE) or $50(PTE) monthly stipend added to your paycheck. In order to receive the stipend, you must complete the Medical Insurance Waiver Request and return it to Human Resources. If you do not complete this form annually, you will not receive stipend monies.

If you opt out because you are covered by another group medical plan and you lose eligibility under that other plan, you have 30 days to enroll in one of the City's medical plan options. **Contact HR Benefits at 480-350-8700 to learn more**.

Terms You Should Know

Accidental Death & Dismemberment (AD&D) – A type of life insurance policy that provides benefits to beneficiaries in the event of a loss due to accidental death or dismemberment.

Coinsurance – The division of the allowed amount to be paid by the benefit plan and the patient. For example, 90/10 means the plan will pay 90% of the allowed amount and the patient is responsible for 10% (after the deductible is satisfied).

Copayment – The fixed fees as shown in the medical benefits summary which generally are paid to the provider at the time services are provided.

Days – Calendar days; not 24-hour periods unless otherwise expressly stated.

Deductible – Depending upon the plan in which you enroll, you may have to pay 100% of your covered medical expenses each plan year, up to a dollar limit. This limit is called a deductible. The PPO plans have both an individual and a family deductible.

Dependent – An individual in the employee's family who is enrolled as a covered participant under the Plan. You must meet the Dependent eligibility requirements to be eligible.

Domestic Partner – An individual of the same/opposite sex with whom you reside, provided you and that individual have jointly signed an affidavit of domestic partnership provided by the HR Department upon your request. Benefits paid on behalf of the Domestic Partner are considered taxable income.

Flexible Spending Accounts (FSA) – Enables participants to pay for certain medical and/or dependent care expenses on a pre-tax basis

Open Enrollment Period – The period of time established by the City as the time when Participants and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Plan Year.

Out-of-Pocket Maximum – To protect you and your family from catastrophic medical expenses, the PPO plans have limits on how much you pay out of your pocket for most covered medical services in a year. This is called an out-of-pocket maximum. Once the deductible, copay, and coinsurance amount you pay for covered expenses reach the individual/family out-of-pocket maximum, the plans will cover 100% of the remaining covered expenses you or your family incur for that plan year.

Plan Year – The 12-month period beginning at 12:01 am on the first day of the initial term (July 1) or any renewal term and ending at midnight of that term. (June 30th)

Preferred Provider Organization (PPO) – A network of medical providers or groups of medical care providers who have entered into written agreements with an insurer to provide health insurance to participants. Participants can save money by taking advantage of the discounted rates and richer benefits with in-network providers. The City of Tempe health plan utilizes Cigna as the PPO network for all plan options.

Pre-Tax Deductions – The deductions taken from your paycheck for the benefits you select before federal, state, and FICA taxes are calculated. Therefore, your taxable income is lower, and you pay fewer income taxes.

Primary Care Physician (PCP) – A Physician who practices general medicine, family medicine, internal medicine, or pediatrics who, through an agreement with health plan, provides basic health care services to you if you have chosen him/her as your PCP. Your PCP also arranges specialized services for you.

Prior Authorization – For pre-planned surgical services and hospital stays, it is strongly recommended to call Allegiance/CIGNA for notification of upcoming services. This enables Allegiance/CIGNA to work with providers and hospitals to ensure appropriate care and billing take place. Failure to get prior authorization for these services can result in a reduction of benefits paid.

Your Medical Plan Options

During the 2024-2025 plan year, the City of Tempe will offer two (2) medical plan options:

- **High Plan Option**
- **Basic Plan Option**

Both Options utilize the CIGNA national Open Access network; you will have access to a vast number of providers nationwide. Maricopa County alone has approximately 2,130 primary care physicians and 6,200 specialists.

In Maricopa County, you also have access to Cigna Medical Group (CMG) in the network. CMG is one of the Valley's largest primary and multi-specialty group practices. Operating in greater Phoenix for 45 years, CMG is an award-winning medical practice with more than 120 primary and specialty care providers practicing at 20 locations. CMG provides high quality, no hassle health care from friendly doctors and many extra services; from lab and digital imaging to urgent care and pharmacy - often available under one roof.

Refer to the contact information (page 4) and online instructions should you need to verify your provider's participation or locate a doctor/hospital in your area.

Allegiance Benefit Plan Management, Inc. (a CIGNA subsidiary) will continue to serve as the City of Tempe's Third-Party Administrator (TPA) for the medical plans. Your Healthcare is Allegiance's first priority, and they work hard to make sure you have access to everything you need to be an active participant in your benefit plan. The Allegiance online services, claims look-up, policy, and provider network listings to help you get the information so that you can focus on getting and staying healthy. Visit these online resources at askallegiance.com. In addition, a friendly, dedicated Customer Service team is available to discuss any of your benefit plan or claims payment questions. Please call a representative Monday-Friday 7am to 6pm Mountain Standard time at: **1-800-259-2296**.

The High Plan Option and Basic Plan Option provide comprehensive medical coverage. You have the freedom to receive care from any provider you choose, under any plan, without first seeing a primary care physician (PCP). Keep in mind that when you receive care from an in-network, participating provider, you get services at discounted rates, and you do not have to file claim forms.

A comparison of benefits chart is provided on page 9. Review the plan designs carefully and think about your health care needs. For instance, what type of expenses do you anticipate in 2024-2025? Will they be mostly preventive and routine? Or, based upon what you know of you and your family's health, is it more likely that you will need more medical care?

Answering these questions will help you determine which plan meets the needs of you and your family.

The amount of your copay/coinsurance will depend upon whether or not you receive treatment from a network provider. Network providers have agreed to offer their services at discounted rates. You will not be balanced-billed for any amounts that exceed the negotiated reimbursement amounts.

SPECIAL NOTE: In-network facilities (like hospitals) may have providers who provide services that are not contracted with the Cigna/Allegiance network. It is up to you to check whether your providers are contracted with the network.

Finding a Provider

Searching for your provider can be done online at askallegiance.com by following the instructions below:

- Go to askallegiance.com
- Click the **"Find a Provider"** link
- Enter Group Number 2001010 and your Member ID from the front of your ID card. Your Member ID will start with 779. Click the **"Accept"** box for the Disclaimer and **click "Submit"**
- If you don't have a Member ID just click the **"Accept"** box for the disclaimer and click **"Submit"**
- On the left-hand side, click "Cigna" and then review how to do a search. Click **"Continue to Cigna provider Search page"**
- As advised in the search instructions, you will need to select your plan which is noted on the front of your ID card. Your group uses the ***Open Access Plus, OA plus, Choice Fund OA Plus*** plan. Complete your search criteria and Click **"Search"**
- The results will pull directly up on the screen. You do have the option to Print/Save your results.

You are also welcome to contact your customer service team at Allegiance by phone at **1-800-259-2296**. If you find that your provider is not represented, feel free to invite them to contact CIGNA at **1-888-663-8081** to develop a contract.

Medical Benefits at a Glance

Health Plan	High Option		Basic Option	
MEDICAL	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$400/person $800/Family	$800/person $1,600/family	$750/person $1,500/family	$1,500/person $3,000/family
Annual Out-of-Pocket Max	$2,750/person $5,500/family	$5,250/person $10,500/family	$4,250/person $8,500/family	$6,500/person $13,000/family
Annual Copay Maximum	N/A	N/A	N/A	N/A
Doctors Visit (Primary /Specialist)	$20/$35 copay	*Plan covers 70%	$25/$40 copay	Plan covers 60%
Recuro Health Consultation Copay	$10	N/A	$10	N/A
Lab/X-rays*	Plan covers 90%	Plan covers 70%	Plan covers 80%	Plan covers 60%
Urgent Care	$50 copay	*Plan covers 70%	$75 copay	*Plan covers 60%
Emergency Room	$150 copay	$150 copay	$175 copay	$175 copay
In/Outpatient Hospital Services (incl. surgeon, lab, & x-ray)*	Plan covers 90% (pre-certification strongly recommended for Inpatient)	Plan covers 70% (pre-certification strongly recommended for Inpatient)	$100 copay, then Plan covers 80% (pre-certification strongly recommended for Inpatient)	$100 copay, then Plan covers 60% (pre-certification strongly recommended for Inpatient)
Outpatient Surgery*	Plan covers 90%	Plan covers 70%	$50 copay, then Plan covers 80%	$50 copay, then plan covers 60%
Physical Therapy	$20 copay	Plan covers 70%	$25 copay	Plan covers 60%
Chiropractic	$35 copay	*Plan covers 70%	$40 copay	*Plan covers 60%
Well Child Care / Immunizations[1]	Plan covers 100%	Plan covers 70%	Plan covers 100%	Plan covers 60%
Well Adult Care[2]	Plan covers 100%	Plan covers 70%	Plan covers 100%	Plan covers 60%
Allergy Shots*	Plan covers 90%	Plan covers 70%	Plan covers 80%	Plan covers 60%
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail (up to a 30-day supply)	Generic: $5 Preferred: 15% coinsurance w/ $15 min / $45 max Non-preferred:30% coinsurance w/ $30 min/ $65 max	Plan covers 70%	Generic: $5 Preferred: 20% coinsurance w/ $20 min / $50 max Non-preferred:35% coinsurance w/ $35 min/ $70 max	Plan covers 60%
Mail-order (up to 100-day supply)[3]	Generic: $10 Preferred: 15% coinsurance w/ $30 min/$90 max Non-preferred:30% coinsurance w/ $60 min/ $130 max	Not covered	Generic: $10 Preferred: 20% coinsurance w/ $40 min/$100 max Non-preferred:35% coinsurance w/ $70 min/$140 max	Not covered

*Subject to Deductible

1.The office visit copayment will be waived when immunization is the only service provided

2.Not all procedures are considered preventive and covered at 100% - check with Allegiance or your provider for what is covered under Well Adult/preventive care. A routine colonoscopy is included under Adult Well Care

3.It is mandatory that you begin using the mail-order plan after your second refill of any medications under all medical plans

Your Prescription Drug Program

When you elect medical coverage under any one of the City's medical plan options, you automatically receive prescription drug benefits. Pharmacy network services are provided by Express Scripts. The participant cost for prescriptions varies per plan option based on the drug tier. **Note: Prescription copays accumulate towards the medical out-of-pocket maximum.**

RETAIL PROGRAM

With Express Scripts, you have access to a network of nearly 60,000 retail pharmacies nationwide where you can have your prescriptions filled for a short-term, 30-day supply of medications. The amount you will be required to pay towards the cost of your medication will depend upon whether the prescription is filled with generic, preferred, or non-preferred medication, as shown in the chart on page 9. You can locate participating pharmacies and check Express Scripts' formulary listing online anytime at express-scripts.com

Prescription Drug Plan – Example of how the plan works

Participant out-of-pocket expense for the prescription drug plan through Express Scripts is based on a coinsurance formula vs. a straight co-pay. Here's an example:
Basic Option:
Plan design (preferred brand) = 20% coinsurance with $20 (minimum)/$50 (maximum)
Price of drug (Preferred drug) $400
20% coinsurance $80
Participant Cost $50
Instead of $80, the participant cost is limited to $50 based on the plan design of $50 being the maximum cost for a preferred brand.

MAIL-ORDER PROGRAM

With Express Scripts, you will also have a convenient mail service. Participants can fill an initial prescription at a retail pharmacy and then receive two refills. If further medication is required (same drug and dosage), participants must utilize the mail-order drug program through Express Scripts. The mail-order drug program is intended to save you time and money when you order up to a 90-day supply of any maintenance medication (e.g., for ongoing health issues such as high blood pressure). With the mail-order program:

- Save money by paying a lower copay, when compared to retail costs for your maintenance medication. You receive up to a 90-day supply of medication for a two-month cost.
- Save time by having the convenience of home delivery.

The first time you use the mail-order program, you will want to ask your doctor to write a 30-day prescription (to use while your mail-order prescription is being processed) and a 90 or 100-day prescription with three refills to submit with your mail-order form. Mail-order forms are available via express-scripts.com.

Your Vision Plan

Vision coverage is provided as part of your health benefits package through Avesis. Under the plan, you can seek care from any licensed optometrist, ophthalmologist, or dispensing optician. However, the plan pays more when you use an Avesis provider.

- A complete eye exam – once per plan year
- $10 Copays for exam
- $10 Copays for Materials (frame or spectacle)
- Standard single vision, bifocal, trifocal, and lenticular lenses covered in full once per plan year after copay. **Youth and Adult polycarbonate are covered in full**; and preferred pricing on other lens options. **Scratch-resistant and anti-reflective coatings are covered in full after copay**; and
- Frames – covered in full up to a **$200** retail allowance) per plan year; or
- Elective contact lenses – once per plan year (in lieu of frame and spectacle lenses) Avesis will provide an allowance of **$200** toward the cost of elective contact lenses. The allowance must be used all at once.
- Medically necessary contact lenses – one per plan year (in lieu of all other lenses). Medically necessary contact lenses obtained from an in-network doctor will be covered in full with prior authorization from Avesis. When they are obtained from an out-of-network doctor, Avesis will provide an allowance (up to $250) toward the cost. Coverage for medically necessary contact lenses, regardless of whether they are obtained from an in- or out-of-network doctor, are subject to review and authorization from Avesis; or
- Refractive Laser Surgery – Onetime/lifetime $150 allowance and up to 25% discount pricing from Avesis providers.
- Participants received discount pricing on additional pairs of glasses from most providers once their benefit has been exhausted.
- Out-of-network reimbursement fee schedule.

This is a brief overview of the vision benefits provided. Please see the Vision Benefit Summary for a complete list of the services covered. For more information, contact HR Benefits at **480-350-8700.

**Participating Walmart/Sam's Club locations cover frames up to $82, Costco up to $119.99.

To locate a participating Avesis provider call **1.800.828.9341** or visit the website at avesis.com.

Your Dental Benefits

The City offers three dental plans: **CIGNA PPO High Option, Cigna PPO Low Option, and CIGNA DHMO**

Under the Cigna Dental Health Maintenance Organization (DHMO), you must select and use one of the Cigna's DHMO network of dentists to receive benefits. Your dentist is also responsible for making any referrals to specialists. The amount that you pay for services is shown on the Patient Charge Schedule found on the Tempe Dental Plans website.

Which Plan is Best for You?	
DHMO	DPPO
✓ Also referred to as Dental Care Access Network ✓ No annual Calendar Year Maximum ✓ No deductibles ✓ Preventive cleanings with little to no cost ✓ You choose a primary care dentist in the DHMO network where you can receive all your care ✓ Orthodontic coverage for children AND adults as listed in the patient charge schedule	✓ Annual Maximum ✓ Subject to plan deductible ✓ Preventive cleanings with little to no cost ✓ You can choose to use any licensed dentist, but see bigger savings if you use a dentist in the Cigna dental network ✓ You can see a specialist without a referral ✓ Orthodontic coverage for children and adults

Cigna PPO option gives you the freedom to choose any dentist anytime. Your benefits are higher if you use one of the Cigna's PPO dentists. Note: You will **not** be receiving a personalized dental card on the Cigna PPO plans; you may download the myCigna Mobile App for ID card. The following provides highlights of each CIGNA PPO dental plan:

	CIGNA High Option	**CIGNA Low Option**
Plan (July 1 – June 30) Year Deductible* ($50 per Individual, up to $150 per family)	$50 Individual $150 Family (Does not apply to any preventive services)	$50 Individual $150 Family (Does not apply to any preventive services)
Preventive Services – Routine oral exams, cleaning, fluoride for children, sealants for children up to age 19, space maintainers/fitting, X-Rays; bitewing and full mouth, emergency treatment	In-Network: 100%, (no deductible) Out-of-Network: 100% (no deductible)	In-Network: 80%, (no deductible) Out-of-Network: 80%, (no deductible)
Basic Services – Fillings (includes Composite Restorations – white fillings on both front and back teeth), endodontic, oral surgery/extractions, periodontics, repair/ rebasing/relining, general anesthetics, routine Scaling	In-Network: 80% Out-of-Network: 60%	In-Network: 60% Out-of-Network: 60%
Major Services – Crowns/gold restorations, dentures (full/partial), fixed bridgework, prosthesis over implant	In-Network: 60% Out-of-Network: 60%	In-Network: 50% Out-of-Network: 50%
Orthodontia Services – Adult and Child(ren)	In-Network: 50% Out-of-Network: 50%	In-Network: 50% Out-of-Network: 50%
Implants	In-Network: 60% Out-of-Network: 60%	In-Network: 50% Out-of-Network: 50%
Plan Year Benefit Maximum* (per person, excludes orthodontia and Class 1 preventive services).	$1,500 (In-Network & Out-of-Network Combined)	$1,500 (In-Network & Out-of-Network Combined)
Lifetime Orthodontia Benefit Maximum (per person)	$2,000 (In-Network & Out-of-Network Combined)	$1,000 (In-Network & Out-of-Network Combined)

***Deductible, maximum annual benefit, and all annual plan limits run on a plan year of July - June** *This information is provided for highlights purposes only. Like most dental insurance policies, CIGNA dental plans contain certain exclusions, reductions, limitations, and terms. Any discrepancies, errors, and omissions between the information on this sheet and the official plan documents will always be governed by the plan documents, including the Group Master Policy and Booklet-Certificate.*

Your Payroll Deductions – Medical and Vision

MEDICAL PLAN RATES – Employees working over 30 hours per week				
	Bi-weekly Premium Non-Wellness City Contribution	*Bi-weekly Premium Non-Wellness Employee Contribution*	*Bi-weekly Premium Wellness City Contribution*	*Bi-weekly Premium Wellness Employee Contribution*
High Option				
Employee	$365.29	$86.54	$365.29	$61.54
Employee + Spouse/Domestic Partner	$624.11	$275.88	$624.11	$250.88
Employee + Child(ren)	$536.26	$214.35	$536.26	$189.35
Employee + Family	$762.15	$372.61	$762.15	$347.61
Basic Option				
Employee	$365.29	$25.00	$365.29	$0.00
Employee + Spouse/Domestic Partner	$624.11	$135.92	$624.11	$110.92
Employee + Child(ren)	$536.26	$98.27	$536.26	$73.27
Employee + Family	$762.15	$195.08	$762.15	$170.08

MEDICAL PLAN RATES – Employees working 20-29 hours per week week				
	Bi-weekly Premium Non-Wellness City Contribution	*Bi-weekly Premium Non-Wellness Employee Contribution*	*Bi-weekly Premium Wellness City Contribution*	*Bi-weekly Premium Wellness Employee Contribution*
High Option				
Employee	$273.97	$177.86	$273.97	$152.87
Employee + Spouse/Domestic Partner	$468.08	$431.91	$468.08	$406.91
Employee + Child(ren)	$402.20	$348.41	$402.20	$323.42
Employee + Family	$571.61	$563.15	$571.61	$538.15
Basic Option				
Employee	$273.97	116.32	$273.97	$91.32
Employee + Spouse/Domestic Partner	$468.08	$291.95	$468.08	$266.95
Employee + Child(ren)	$402.20	$232.34	$402.20	$207.34
Employee + Family	$571.61	$385.61	$571.61	$360.62

VISION PLAN RATES - Employees working 40 hours per week		
	Bi-weekly City Contribution	**BIWEEKLY* Employee Contribution*
Avesis		
Employee	$3.68	$0.00
Employee + Spouse/Domestic Partner	$6.02	$1.00
Employee + Child(ren)	$6.42	$1.17
Employee + Family	$7.92	$1.82

VISION PLAN RATES – Employees working 20-39 hours per week		
	Bi-weekly City Contribution	**BIWEEKLY* Employee Contribution*
Avesis		
Employee	$2.76	$0.92
Employee + Spouse/Domestic Partner	$4.51	$2.50
Employee + Child(ren)	$4.81	$2.78
Employee + Family	$5.94	$3.80

Your Payroll Deductions – Dental

DENTAL PLANS – Employees Working 40 hours per week		
	Bi-weekly City Contribution	**BIWEEKLY* Employee Contribution*
CIGNA High Plan		
Employee	$13.42	$7.53
Employee + Spouse/Domestic Partner	$21.87	$17.93
Employee + Child(ren)	$23.76	$20.24
Employee + Family	$33.43	$32.13
CIGNA Low Plan		
Employee	$13.42	$0.00
Employee + Spouse/Domestic Partner	$21.87	$3.63
Employee + Child(ren)	$23.76	$4.43
Employee + Family	$33.43	$8.57
CIGNA DMO Plan		
Employee	$7.22	$0.00
Employee + Spouse/Domestic Partner	$9.90	$1.15
Employee + Child(ren)	$11.83	$1.98
Employee + Family	$17.94	$4.60

DENTAL PLAN RATES – Employees working 20-39 hours per week		
	Bi-weekly City Contribution	**BIWEEKLY* Employee Contribution*
CIGNA High Plan		
Employee	$10.07	$10.88
Employee + Spouse/Domestic Partner	$16.40	$23.39
Employee + Child(ren)	$17.82	$26.18
Employee + Family	$25.07	$40.49
CIGNA Low Plan		
Employee	$10.07	$3.36
Employee + Spouse/Domestic Partner	$16.40	$9.09
Employee + Child(ren)	$17.82	$10.37
Employee + Family	$25.07	$16.93
CIGNA DMO Plan		
Employee	$5.41	$1.80
Employee + Spouse/Domestic Partner	$7.43	$3.62
Employee + Child(ren)	$8.87	$4.94
Employee + Family	$13.46	$9.08

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Tempe

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2013 Medical Expenditure Panel Survey / MEPS

Common Conditions Treated

- Acid Reflux
- Allergies
- Asthma
- Nausea
- Bronchitis
- Cold & Flu
- Infections
- Bladder Infection
- Rashes
- Sinus Conditions
- Sore Throat
- Thyroid Conditions
- UTIs
- And More…

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Visit recurohealth.com

Disclaimer: Recuro services are for non-emergency conditions only. Recuro does not replace the primary care physician, services are not considered insurance or a Qualified Health Plan under the Patient Protection and Affordable Care Act. Recuro doctors do not prescribe DEA controlled substances (schedule I-IV) and does not guarantee that a prescription will be written. For updated full disclosures, please visit recurohealth.com

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Your Advocate can help!

A key to good health is to take advantage of the preventive care benefits of your medical plan.

Do you understand your preventive care options?

Your Advocate can:

- Identify preventive care tests you are due for, based on your age and gender
- Explain how your benefits cover these important tests (most are covered at 100%)
- Provide a free cost comparison for up to three local providers for each preventive care test, helping you save money on your medical bills
- Schedule appointments on your behalf
- Review your EOBs and medical bills following your test/procedure to ensure accuracy

Call your Advocate for any benefits or health care questions throughout the year.

FREE & CONFIDENTIAL

Your Advocacy Support

Your Advocate can save you time, money & frustration by:

- Answering your questions
- Maximizing your benefits
- Navigating the system

(866) 253-2273

advocate@optavise.com

Mon - Fri: 7 a.m. – 8 p.m. (CST)
Saturday: 8 a.m. – 1 p.m. (CST)

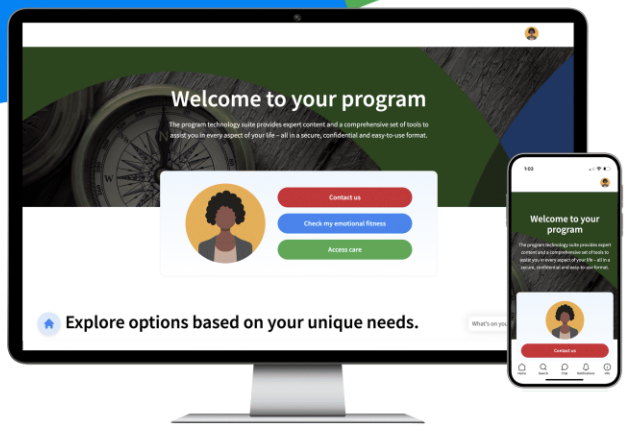
Chat with an Advocate and find your benefits information:

tempe.dphmemberportal.com

Get rewarded with 20% of the savings up to $500 for making smart health care decisions! Call us for details.

Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues



In-the-moment support

Reach a licensed clinician by phone 24/7/365 when you call for assistance.

Short-term counseling

Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.

Coaching

Get assistance from a Coach to boost your emotional fitness, learn healthy habits, establish new routines, build your resilience and more.

Work-life benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.

Confidentiality

Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.

Your web portal and mobile app

- Create a personal profile to quickly access support from a licensed clinician
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos

Start with Mental Health Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator assessment. You'll instantly receive personalized guidance to access care and support.

supportlinc
EMPLOYEE ASSISTANCE

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1-888-881-5462

supportlinc.com
group code: **cityoftempe**

City Paid Benefits

These are the benefits that all regular City employees receive. The City pays 100% of the cost of these benefits:

GROUP TERM LIFE INSURANCE
All employees receive one times their annual salary in group term life insurance coverage. Note: Police & Fire, please refer to your MOU.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
All employees receive one times their annual salary in group Accidental Death and Dismemberment insurance coverage. This policy pays a benefit in the event of your death due to an accident. It also pays a pro-rated benefit in case of an accidental dismemberment.

COMMUTER INSURANCE
All employees receive $250,000 of coverage for death due to an accident while commuting to and from work.

LONG-TERM DISABILITY (LTD)
LTD Insurance is provided as a source of income protection. Should you become disabled as a result of injury or illness, this coverage will provide you 66⅔% of your gross monthly salary. LTD benefits begin after the 90th day of disability. There is a one-year waiting period for new employees.

ALLEGIANCE CARE UTILIZATION MANAGEMENT
The Allegiance Care Utilization Management team reviews the patient's medical history and assesses the proposed care for appropriateness. Their detailed review and the use of nationally recognized criteria by Milliman USA, promotes cost savings by evaluating the appropriateness, medical need and efficiency of health care services, procedures and facilities. Each review is also an opportunity to identify high-risk individuals who may benefit from case management.
1-877-792-7827

HEALTH ADVOCATE
Optavise can help you find a doctor, claims issues and research procedure cost. **1-866-253-2273**

ALLEGIANCE MATERNITY CARE MANAGEMENT
Our health plan has a maternity management program to support and assist you with having a healthy pregnancy. The program is designed to provide important pregnancy-related information and educational material, at no cost to you.

You will have a personal Maternity Nurse who will be available to you either by telephone or email throughout your pregnancy. Your nurse will continue to be a resource for you during your first few weeks as a new mother. Register within the first trimester of your Pregnancy, you will receive **a $150 gift card** upon completion of the program. If you register within the second trimester, you will receive a **$75 gift card** upon completion of the program. For more information and to register today call the Allegiance Maternity Care Management Nurse at **1-877-792-7827**, Option 1 Or Register Online at **www.askallegiance.com**.

ALLEGIANCE CARE MANAGEMENT
Allegiance Care Management team identifies at-risk individuals who would benefit from case management. Each individual is assigned a Case Manager who works with the individual until the case is resolved. The nurse's approach is one of partnership with the member, provider, facility, and Plan Sponsor.

One of the unique aspects of our case management service is that Allegiance Care Management devotes great effort, not only toward the management of the medical needs of the individual members but also toward the management of the financial risk that exists for the groups they serve. **1-877- 792-7827**

City Paid Benefits Continued…

LIVE WELL SOLUTIONS

24 Hour Nurseline

The City of Tempe offers you and your family members a Nurseline service through Live Well Solutions. The Nurseline is available 24 hours a day to provide health advice and information concerning you and your family. The Nurseline is staffed by registered nurses who have an average of 20 years' experience and encourage patient self-care in areas including:

- Treating common conditions at home
- Education about warning signs indicating that medical attention should be sought
- Coaching you or a family member on managing a new or chronic condition
- Counseling on healthy habits and risk reduction (such as tobacco cessation and weight control)

To Access Nurseline Services through Live Well Solutions call: **1-866-220-3138**

Voluntary Life & AD&D

We encourage you to look at the voluntary benefits that the City offers through convenient payroll deduction.

VOLUNTARY LIFE INSURANCE

You and your spouse/domestic partner can elect additional life insurance in amounts from $20,000 - $500,000. You can cover your children for $5,000 or $10,000. Evidence of good health is required for amounts over $200,000 or if you are enrolling outside of your initial eligibility. Deductions are taken once a month, on the 2nd paycheck of the month.

VOLUNTARY AD&D

You can elect additional AD&D coverage on you and your family members in amounts from $25,000 - $500,000. Enroll at any time. Evidence of good health is not required.

Money Saving Opportunities

The City also offers you several money-saving opportunities. You can pay for eligible Healthcare and dependent care expenses with before-tax dollars through two Flexible Spending Accounts (FSA's) offered by the City:

HEALTH FSA

Before the start of each Flex Plan year, you may elect to use "before-tax" dollars to pay for your out-of-pocket medical expenses. Dental and vision expenses may be reimbursed, too. Eligible expenses include those defined by IRS Code, Section 213(d).

The amount you elect will reimburse you for eligible expenses that you, your spouse and your eligible dependents incur during the plan year. The entire annual amount you elect, up to a minimum election of $130 to a maximum election of $3,200, can be used at any time during the plan year. All you have to do is elect the amount you want withheld before taxes from each paycheck. You must reelect this benefit at open enrollment every year. Unused Medical contributions up to $640 can be rolled over for the next plan year, but you must re-enroll for the new plan year with a minimum election of $130 annually.

DEPENDENT CARE DCA

If both you and your spouse work or you are a single parent, you may have dependent care expenses. You may also be eligible for the Federal Child Care Tax Credit, but not both. So, compare both before making your annual election. A dependent receiving care must live in your home at least eight (8) hours per day. Your Flex Plan lets you use "before-tax" dollars to pay care expenses for children age 12 and under, or individuals unable to care for themselves. The care must be necessary for you and your spouse to remain gainfully employed. The care may be provided through live-in care, babysitters and licensed day care centers. You cannot use "before-tax" dollars to pay your spouse or one of your children under the age of nineteen (19) for providing care. Schooling expenses at the kindergarten level and above are not reimbursable. Neither overnight camp nor nursing home care is reimbursable. The maximum you can elect, in a calendar year, is equal to the smallest of the following:

- $5,000-married and filing federal taxes jointly or single parent;
- $2,500-married and filing a separate federal tax return; or your spouse's earned income.

Money Saving Opportunities Continued…

MID-YEAR ELECTION CHANGES

Be careful in the amount you choose to elect. Be sure to elect no more than you know you and your tax dependents are going to use within the plan year. Under the "use-or-lose" rule, any unused dependent care FSA contributions by the end of the plan year will not be returned to you. Any Health FSA contributions above $640 by the end of the 2024 plan year cannot be returned to you. In addition, no changes to your election may be made during the plan year unless you experience a "qualifying event". Mid-year election changes usually must be made within 30 days of a qualifying event. Changes are limited and differ for each pre-tax option. For more information about mid-year election changes, please contact your human resources department or Allegiance.

REIMBURSEMENT

Claims can be submitted electronically, scanned, faxed or mailed. Allegiance processes claims each business day with weekly payments. Claims are normally processed within five business days of receipt. Please inquire about the Debit card option or the Joint Processing option. **Check Payment:** ***You usually have a check in your mailbox less than a week after you have submitted your claim.***

Direct Deposit: Send in the Direct Deposit form with a voided check and Allegiance will electronically deposit reimbursements directly into your checking account. You may also elect this option online with Allegiance. Since your contributions are deducted from your pay on a pre-tax basis, you do not pay Federal income or Social Security taxes – and, in most cases, state and local income taxes – on your contributions. So, by contributing to an FSA, you can lower your taxes. To participate in an FSA, you **must enroll each year**. Participation in this plan does not automatically continue from year to year. To enroll, you'll need to select a contribution amount for one or both FSA's. Once you make an election, you cannot change it unless you have a qualified status change during the year that permits you to change your contribution amount. Make sure an expected expense is eligible before you elect your FSA contribution(s). Use the worksheet on page 19 to help you determine your expenses for 2024-2025.

To learn more about the FSA's offered by the City of Tempe, contact HR benefits at **480-350-8700.**

BEFORE YOU ENROLL IN AN FSA:

- You should be conservative when you estimate how much your health care and/or dependent care expenses are likely to be during a plan year. Unused portions of dependent care will be forfeited. Unused Medical contributions up to $640 can be rolled over for the next plan year, but you must re-enroll for the new plan year with a minimum election of $130 annually.
- Understand how reimbursement works – Health Care FSA contributions may only be used for reimbursement of eligible health care expenses for you and your dependents. Dependent Care FSA contributions may only be used for reimbursement of eligible dependent care expenses.
- Remember, as a result of the CARES Act **over the counter medication such as pain relief medication, cold and flu products, allergy products, heartburn medications, and menstrual products** are now eligible expenses without the need of a prescription. Make sure to hold on to receipts as you may still have to substantiate your claim per the IRS rules.

WORKSHEET

Estimate your FSA Expenses for Healthcare

Healthcare		Dependent Care	
Deductibles/Copays	$	Child Care Expenses	$
Coinsurance	$	Elder Care Expenses	$
Prescription Drug Coinsurance / Copays	$	Other Eligible Expenses	$
Expenses for glasses, contact lenses, etc. not covered by the Vision Plan	$		
Hearing Aids and Batteries	$		
Dental expenses not covered by the Dental Plan	$		
Other Eligible Expenses	$		
Total Per Year*	$	Total Per Year*	$

Do not include the amount you contribute for coverage – the amount is not eligible, per the IRS.
*Enter this amount in the FSA section of the enrollment form.

Allegiance will administer the FSA accounts.
Only expenses incurred during the plan year (July 1 through June 30) are eligible for reimbursement.

FREE MONEY FOR MEDICAL EXPENSES!

The City has a unique benefit called Mediflex. All employees eligible for Medical Insurance with the City of Tempe will receive $56.42 in Mediflex money on the first paycheck of each month - which adds up to $677.08 per year. You can use this money to pay for medically-related bills not covered by insurance (like copays, deductibles, vision, and dental expenses).

You are not taxed on the money you receive from Mediflex, and any unused amounts stay in your account from year to year. In order to receive reimbursement, your claim must be at least $20. The Mediflex plan adheres to IRS guidelines in terms of whose expenses can be reimbursed and what is considered eligible medical expenses.

Note: Mediflex is not applicable to Fire employees covered under the Fire MOU.

SAVING FOR RETIREMENT?

The City offers you a way to help save for your retirement through the Defined Contribution Retirement Savings Program. There are four plans available – a pre-tax 401(k) plan, a traditional 457, Roth 401(k), and Roth 457 plans.

Administered by Nationwide Retirement Services, these plans offer nearly 20 investment options. You choose the amount to contribute to each paycheck. The major advantage is that your contributions are made on a pre-tax basis (for 401(k), and traditional 457), reducing your current tax liability. In addition, your contributions grow on a tax-deferred basis. There is an added incentive to participate – the City matches your contributions based on years of service. Because these plans are intended to help you save for retirement, there are strict guidelines for withdrawing your money.

You are eligible to participate after 30 days of employment but can enroll or change your deferral election at any time. Our Nationwide representative holds monthly enrollment meetings for new employees. Remember, the money you save now can make a substantial difference in your standard of living after you retire!

Note: Employees covered under a Memorandum of Understanding should refer to their MOU for any differences.

Important Plan Information

MID-YEAR CHANGES TO YOUR MEDICAL, DENTAL, AND VISION PLAN ELECTIONS

IMPORTANT: After this open enrollment period is completed, generally you will not be allowed to change your benefit elections or add/delete dependents until next year's open enrollment unless you have a Special Enrollment event or a Mid-year Change in Status.

Special Enrollment Event: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. You and your dependents may also enroll in this plan if you (or your dependents):

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact HR Benefits at **480-350-8700**.

Mid-Year Changes are Status Events:

The following events may allow certain changes in benefits mid-year, as permitted by the IRS:

- Change in legal marital status (e.g., marriage, divorce/legal separation, death).
- Change in number or status of dependents (e.g., birth, adoption, death).
- Change in employee/spouse/dependents' employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a Qualified Medical Support Order (QMCSO)
- Entitlement or loss of entitlement to Medicare or Medicaid
- Certain changes in the cost of coverage, the composition of coverage, or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify the Plan in writing within 30 days of the mid-year change in status by contacting HR Benefits. The plan will determine if your change request is permitted, and if so, changes become effective on the first day of the month following the date of the event if the application for coverage is timely received (except for newborn and adopted children who are covered back to the date of birth, adoption, or placement for adoption). Documentation, including birth certificate and social security number, marriage certificate, loss of coverage or proof no longer residing in the United States, must be submitted to the Plan within thirty (30) days of notification. Failure to provide documentation within the timeframe will result in termination of dependent's coverage. You must immediately provide written notification and documentation to HR in the event of legal separation, divorce or removal of Domestic Partner and applicable children. Enrolling or maintaining ineligible dependents on any of the City's Healthcare plans is a violation of City policy.

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 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. For more information on WHCRA benefits, contact HR Benefits at **480-350-8700**.

Important Plan Information Continued….

PRIVACY NOTICE
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 health care 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 the plan. To get another copy of this Notice, write or call the Benefits Department at 20 E. 6th Street, Tempe, AZ 85281, **480-350-8700.**

MANDATORY INSURER REPORTING LAW
Under this federal law, insurance companies and medical plan claim administrators (like CIGNA) are required to report certain information to the Secretary of Health and Human Services to coordinate benefits with Medicare. As such, all plan participants are required to provide social security numbers and/or Medicare Health Insurance Claim Numbers (HICN) when enrolled in medical plan benefits. You will be asked to enter social security numbers for all dependents you cover on your medical plan. For more information, contact HR Benefits at 480-350-8700.

Eligibility Audits
During the plan year, you may be asked to participate in a dependent verification Eligibility Audit for the eligibility and status of covered family members. This will apply to new hires and existing employees. You may be asked to provide document(s) for proof of eligibility, such as a birth certificate, marriage license, etc.

MEDICARE NOTICE OF CREDITABLE COVERAGE
If you or your eligible dependents are currently Medicare-eligible or will become Medicare-eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under this Plan is or is not creditable (as valuable as) Medicare's prescription drug coverage. To find out whether the prescription drug coverage under the plans offered by the City of Tempe is or is not creditable, you should review the plan's Medicare Part D Notice of Creditable Coverage, available from HR Benefits.

Brown & Brown

This Benefits Guide is intended to be only an overview of the benefits program. Complete details about how the plans work are included in the policies, summary plan descriptions, and plan documents (legal documents), which are available online or from your Benefits Representative on request. If there are any inconsistencies between this Enrollment Guide and the legal documents, the legal documents will govern. The City reserves the right to change or end the benefits program at any time.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefits information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of a discrepancy between the Guide and the actual plan documents the actual plan, the documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, please refer to your Employee Manual for additional information or contact your Benefits Manager.

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 **1-877-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 **1-866-444-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 January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 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
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.askallegiance.com or call 1-800-877-1122. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400 individual/$800 family network $800 individual/$1,600 family non-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible (embedded) until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network office visit, preventive care, urgent care are not subject to deductible.	This plan covers some items and services even if you haven't met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at http://www.healthcare.gov/coverage/preventive-care.benefits.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,750 individual/$5,500 family network $5,250 individual/$10,500 family non-network medical and pharmacy combined	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits (embedded) until the overall family out-of-pocket limits has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.askallegiance.com or call 1-800-877-1122 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

	All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.			
Common Medical Event	**Services You May Need**	**In-Network Provider (You will pay the least)**	**Non-Network Provider (You will pay the most)**	**Limitations & Exceptions**
If you visit a health care provider's office or clinic	Primary care (PCP) visit to treat an injury or illness	$20 copayment/visit deductible waived	30% coinsurance	Copayment applies only for the office visit charge (evaluation and management). Additional charges are subject to deductible and coinsurance.
	Specialist (SPC) visit	$35 copayment/visit deductible waived	30% coinsurance	
	Preventive care/screening/ immunization	no charge deductible waived	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.askallegiance.com or 1-800-877-1122, or www.express-scripts.com.	Generic drugs	$5 copayment retail $10 copayment mail order		Charges payable through the Plan's Pharmacy Benefit Manager program. Copayments may not apply to certain PPACA preventive care prescriptions. Coverage is limited to 30 day supply for retail; 100 day supply for mail order. Mail order mandatory after 2 fills for maintenance medications. Certain prescriptions require prior authorization.
	Preferred brand drugs	15% copayment, $15 min. $45 max retail; 15% copayment, $30 min. $90 max mail order		
	Non-preferred brand drugs	30% copayment, $30 min. $65 max retail; 30% copayment, $60 min. $130 max mail order		
	Specialty drugs	Specialty drugs are subject to non-preferred brand copayment		Specialty Prescriptions must be obtained from the Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copayment/visit deductible waived	$150 copayment/visit deductible waived	Non-emergency use of emergency room subject to 10% coinsurance after $100 copayment in-network, deductible applies; 30% coinsurance non-network. Copayment waived if admitted and inpatient hospital benefits will apply.
	Emergency medical transportation	10% coinsurance	10% coinsurance after in-network deductible	None
	Urgent care	$50 copayment/visit deductible waived	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-certification recommended for all inpatient admissions. Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	

	All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.			
Common Medical Event	**Services You May Need**	**In-Network Provider (You will pay the least)**	**Non-Network Provider (You will pay the most)**	**Limitations & Exceptions**
If you need mental health, behavioral health, or substance abuse services	Office visits	$20 copayment/visit deductible waived	30% coinsurance	None
	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Pre-certification recommended for all inpatient admissions.
If you are pregnant	Office visits	$20 copayment PCP or $35 copayment SPC deductible waived if billed per office visit	30% coinsurance	Pre-certification recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Cost sharing does not apply for preventive services. Depending on the type of services, deductible, coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance if billed as global fee	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Pre-treatment review recommended for home health care services.
	Rehabilitation services	$20 copayment/visit deductible waived	30% coinsurance	None
	Habilitation services	$20 copayment/visit deductible waived	30% coinsurance	None
	Skilled nursing care	10% coinsurance	30% coinsurance	Pre-certification recommended for all inpatient admissions.
	Durable medical equipment	10% coinsurance	30% coinsurance	Pre-treatment review recommended for charges exceeding $5,000.
	Hospice services	10% coinsurance	30% coinsurance	Includes bereavement counseling. Pre-certification recommended for all inpatient admissions.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	10% coinsurance	30% coinsurance	Coverage limited to glasses or contact lenses following cataract surgery; $100 maximum benefit.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care (Adult)	• Infertility treatment • Long-term care	• Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery • Chiropractic care	• Hearing aids • Non-emergency care when traveling outside of the U.S.	• Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at: 1-877-267-2323 x61565 or www.cciio.cms.gov, or contact 1-800-877-1122 or www.askallegaince.com. Additionally, a consumer assistance program can help you file your appeal. Consumer assistance programs available at www.dol.gov/ebsa/healthreform, or www.cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com or call 1-800-877-1122.

About these Coverage Examples:

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

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

The plan's overall deductible	$400
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,670**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$400
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$400
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

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

Note: The cost sharing amounts in the Coverage Examples are based on the CMS Cost Sharing Calculator (CECSC) www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html **used to estimate out-of-pocket expenses. The coverage examples are estimated costs only, and may not accurately reflect actual costs. The actual care you receive will be different from these examples, and the cost of that care will also be different.**

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

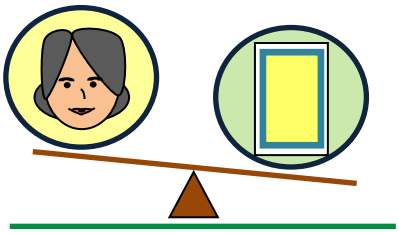
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

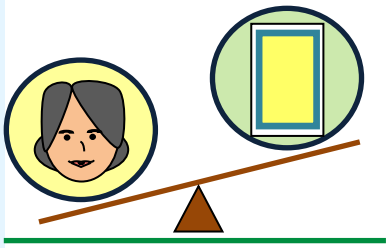
Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

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

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

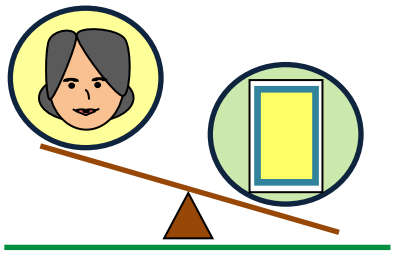
Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

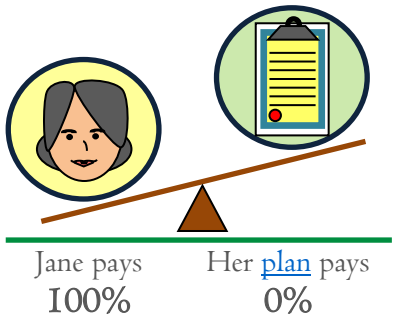
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

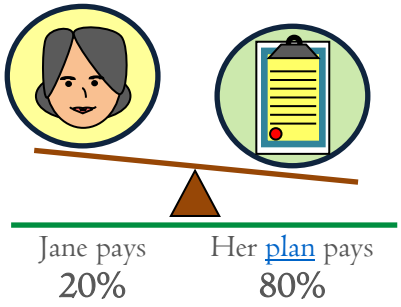
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

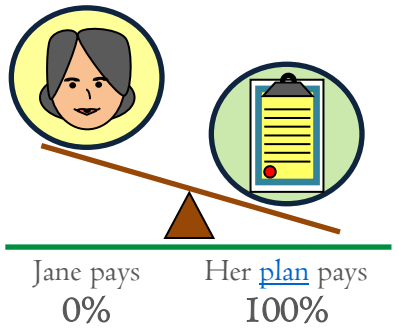
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

Language Access Services: The information below is a requirement of Section 1557 of the Affordable Care Act effective August 18, 2016. It is required to assist those who may need assistance with the English language or translation assistance to a different language in which they are more fluent.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتاح لك مجانًا. اتصل برقم 1063-999-855 (رقم هاتفي نصي: 1-855-999-1062).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063）

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけま.1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.askallegiance.com or call 1-800-877-1122. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 individual/$1,500 family network $1,500 individual/$3,000 family non-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible (embedded) until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes. In-Network office visit, preventive care, urgent care are not subject to deductible.	This plan covers some items and services even if you haven't met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at http://www.healthcare.gov/coverage/preventive-care.benefits.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,250 individual/$8,500 family network $6,500 individual/$13,000 family non-network medical and pharmacy combined	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits (embedded) until the overall family out-of-pocket limits has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.askallegiance.com or call 1-800-877-1122 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care (PCP) visit to treat an injury or illness	$25 copayment/visit deductible waived	40% coinsurance after deductible	Copayment applies only for the office visit charge (evaluation and management). Additional charges are subject to deductible and coinsurance.
	Specialist (SPC) visit	$40 copayment/visit deductible waived	40% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge deductible waived	40% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.askallegiance.com or 1-800-877-1122, or www.express-scripts.com.	Generic drugs	$5 copayment retail $10 copayment mail order		Charges payable through the Plan's Pharmacy Benefit Manager program. Copayments may not apply to certain PPACA preventive care prescriptions. Coverage is limited to 30 day supply for retail; 100 day supply for mail order. Mail order mandatory after 2 fills for maintenance medications. Certain prescriptions require prior authorization.
	Preferred brand drugs	20% copayment, $20 min. $50 max retail; 20% copayment, $40 min. $100 max mail order		
	Non-preferred brand drugs	35% copayment, $35 min. $70 max retail; 35% copayment, $70 min. $140 max mail order		
	Specialty drugs	Specialty drugs are subject to non-preferred brand copayment		Specialty Prescriptions must be obtained from the Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$175 copayment/visit deductible waived	$175 copayment/visit deductible waived	Non-emergency use of emergency room subject to 20% coinsurance after $125 copayment in-network, deductible applies; 30% coinsurance non-network. Copayment waived if admitted and inpatient hospital benefits will apply.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after in-network deductible	None
	Urgent care	$75 copayment/visit deductible waived	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible and $100 copayment/admit	40% coinsurance after deductible	Pre-certification recommended for all inpatient admissions. Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com or call 1-800-877-1122.

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

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
If you need mental health, behavioral health, or substance abuse services	Office visits	$25 copayment/visit deductible waived	40% coinsurance after deductible	None
	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Inpatient services	20% coinsurance after deductible and $100 copayment/admit	40% coinsurance after deductible	Pre-certification recommended for all inpatient admissions.
If you are pregnant	Office visits	$25 copayment PCP or $40 copayment SPC deductible waived if billed per office visit	40% coinsurance after deductible	Pre-certification recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Cost sharing does not apply for preventive services. Depending on the type of services, deductible, coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance if billed as global fee	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible and $100 copayment/admit	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Pre-treatment review recommended.
	Rehabilitation services	$25 copayment/visit deductible waived	40% coinsurance after deductible	None
	Habilitation services	$25 copayment/visit deductible waived	40% coinsurance after deductible	None
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification recommended for all inpatient admissions.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Pre-treatment review recommended for charges exceeding $5,000.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Includes bereavement counseling. Pre-certification recommended for all inpatient admissions.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	20% coinsurance after deductible	40% coinsurance after deductible	Coverage limited to glasses or contact lenses following cataract surgery; $100 maximum benefit.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care (Adult)	• Infertility treatment • Long-term care	• Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery • Chiropractic care	• Hearing aids • Non-emergency care when traveling outside of the U.S.	• Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at: 1-877-267-2323 x61565 or www.cciio.cms.gov, or contact 1-800-877-1122 or www.askallegaince.com. Additionally, a consumer assistance program can help you file your appeal. Consumer assistance programs available at www.dol.gov/ebsa/healthreform, or www.cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? **Yes**

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

Does this plan meet the Minimum Value Standards? **Yes**

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

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com or call 1-800-877-1122.

About these Coverage Examples:

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

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

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$100
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,910**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$300
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,770**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

Note: The cost sharing amounts in the Coverage Examples are based on the CMS Cost Sharing Calculator (CECSC) www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html **used to estimate out-of-pocket expenses. The coverage examples are estimated costs only, and may not accurately reflect actual costs. The actual care you receive will be different from these examples, and the cost of that care will also be different.**

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

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

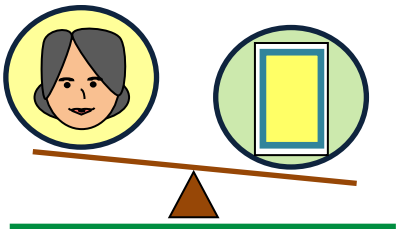
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

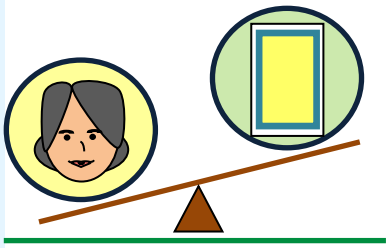
Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

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

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

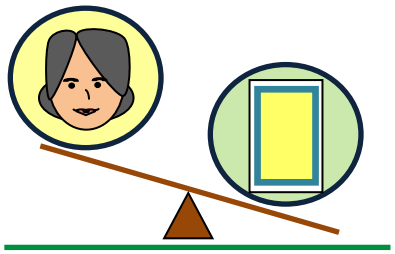
Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

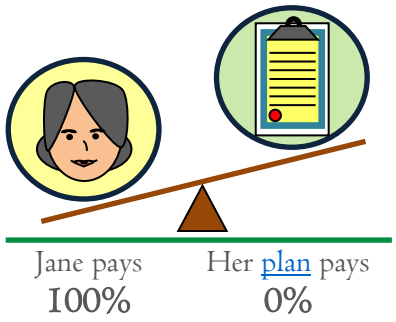
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

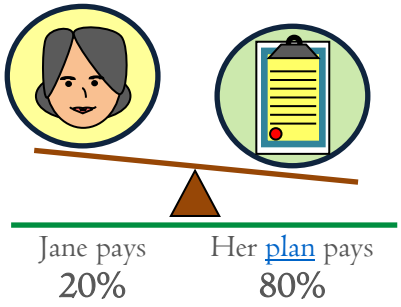
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

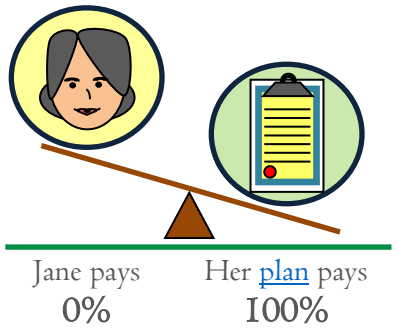
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

Language Access Services: The information below is a requirement of Section 1557 of the Affordable Care Act effective August 18, 2016. It is required to assist those who may need assistance with the English language or translation assistance to a different language in which they are more fluent.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتاح لك مجانًا. اتصل برقم 1063-999-855 (رقم هاتفي نصي: 1-855-999-1062).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063）

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけま.1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).