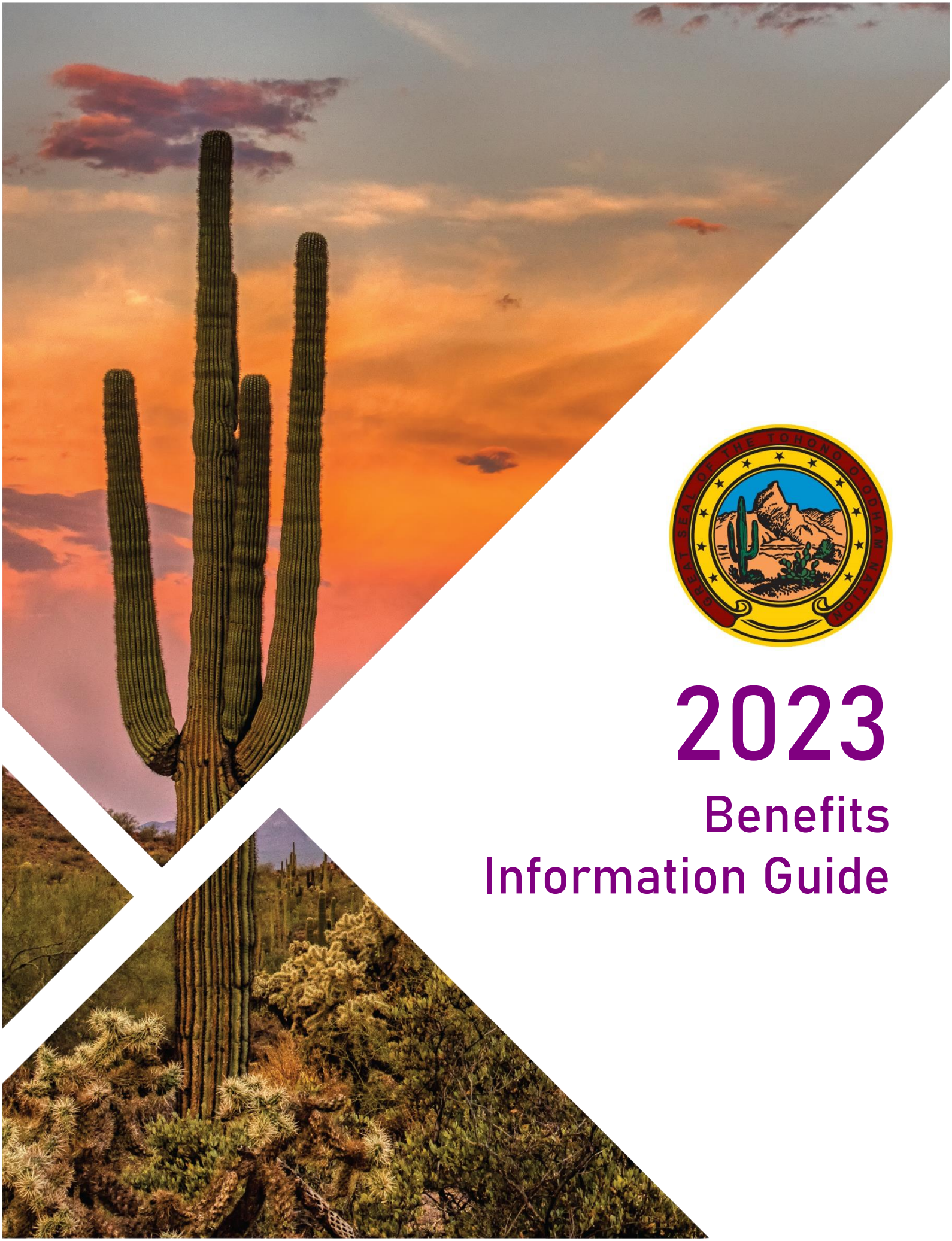


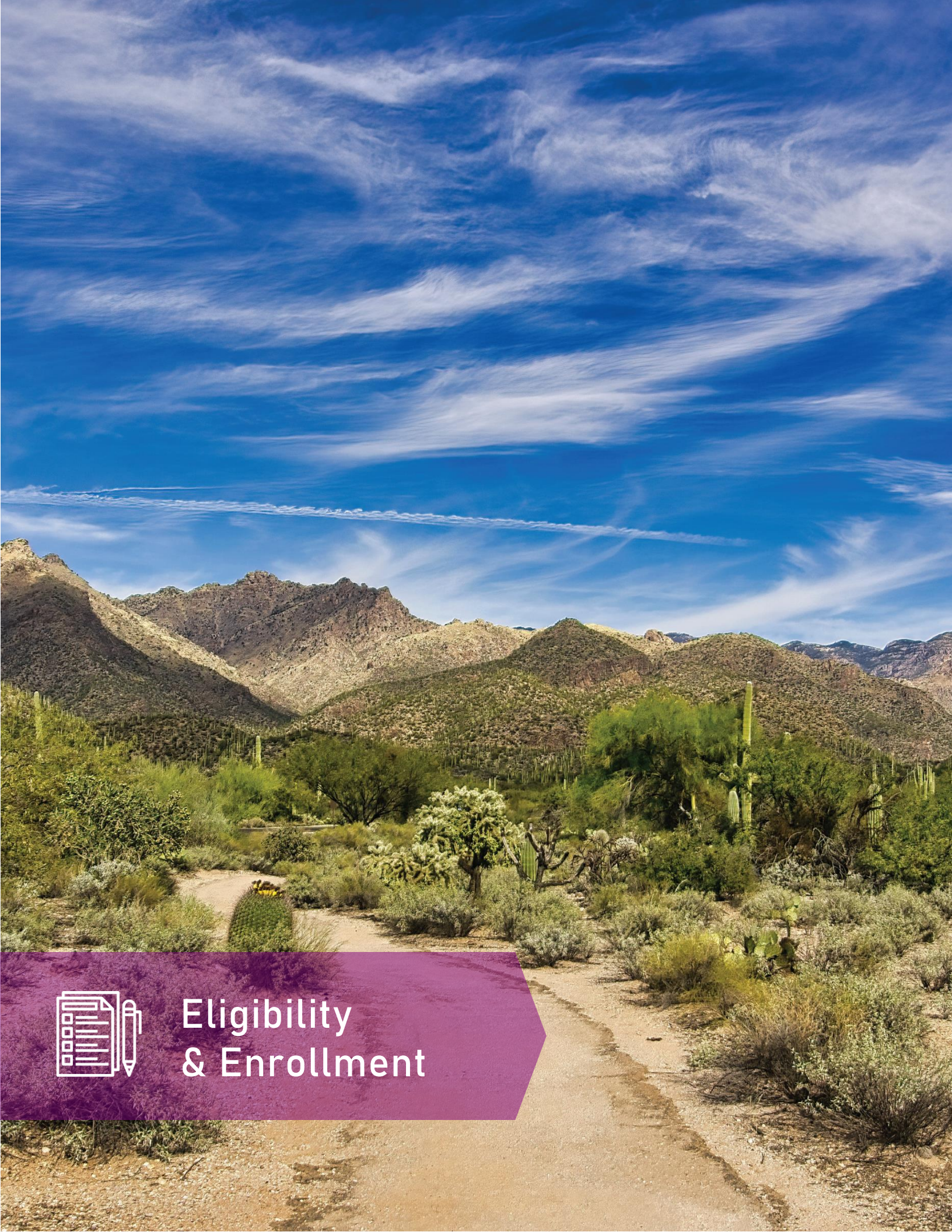
2023

Benefits Information Guide

Discover Your Benefits

Let's explore your benefit plan options, programs and resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page (37) for more details.



Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

If you are an employee that is expected to regularly work a minimum of 20 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/domestic partner and/or eligible children.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee's domestic partner that does not meet the definition of the employee's tax dependent under IRC Section 152.

When does coverage begin?

Regular, full-time employees: You are eligible for coverage on the first of the month following 30 days from your date of hire.

Your enrollment choices remain in effect through the end of the benefits plan year, October 1, 2023 - September 30, 2024. If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status event during the plan year. Please check with your plan administrator and your Section 125 plan document on any applicable status change events that would allow you to make a mid-year election change.

How do I get started with my enrollment?

isolved

Available as an app on iOS and Android

- Go to myisolved.com and log in using your Employee Self Service People Cloud login credentials
- To access your enrollment, select Benefits Enrollment or Open Enrollment
- Follow the steps outlined in isolved to complete your enrollment

What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a change in status event as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the status change event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's loss or gain of coverage through our organization or another employer.
- An employee (1) was expected to average at least 30 hours of service per week, (2) has a change in employment status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange due to open enrollment or special enrollment period, and coverage is effective no later than the day immediately following the revocation of your employer-sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of status change events, please refer to the "Legal Information Regarding Your Plans" contents.

Do I have to enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please visit www.cciio.cms.gov.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, log in to isolved. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on October 1, 2024, unless a change in status event occurs.


Medical

Medical

Which plan type is right for you?

PPO	HDHP
A Preferred Provider Organization (PPO) Plan contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Using providers that belong in the plan's network will provide a higher benefit, but you have the flexibility to see a provider outside the network, generally for an additional cost.	A High-Deductible Health Plan (HDHP) combines traditional medical coverage with a Health Savings Account (HSA). As evident by the name, this plan has a higher deductible you must reach before the plan kicks in.
Advantages • Broader choice of providers. • No referrals required for specialists.	 • Tax advantages with an HSA. • Lower monthly premiums.
Out-of-pocket costs You'll be responsible for copays and coinsurance, but your deductible will be lower than the HDHP plan.	 Your out-of-pocket expenses may be mostly upfront, since you'll need to satisfy your deductible before your plan kicks in.
Ideal if... ... you prefer flexibility and provider options, and if you're comfortable paying more out of your paycheck and less out of pocket for your deductible.	 ... you don't usually need much care throughout the year, this plan might be right for you. Make sure you have funds set aside to pay towards the deductible.
Note: You may choose in or out-of-network care. However, in-network care provides you a higher level of benefit.	 It is beneficial to keep records of your healthcare expenses by retaining your receipts.

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit www.azblue.com.

Benefits Information on the Go

MyBlue AZ – Mobile App!

The BCBSAZ app provides you with greater access to your insurance information. Use the app to:

- View your personalized insurance dashboard.
- Display your BCBSAZ ID Card.
- Locate physicians, hospitals, or other healthcare professionals nationwide.
- Learn about benefit discount programs, like dental, vision and pharmacy.

Search for MyBlue AZ mobile app in the App Store or Google Play to get started!

How to Find a Provider

BCBSAZ

1. Go to azblue.com and click “Find a Doctor”
2. Choose “I am NOT yet a member,” then click on the box that reads “But might get a BCBSAZ health plan through my employer.”
3. Click on the arrow next to “Choose a Network.”
4. Choose PPO or EPO then click “Search.”
5. You are now ready to search for a provider.

Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug's tier.

Generic formulary (Tier 1): Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.

Brand name medications (Tier 2): A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.

Non-formulary prescriptions (Tier 3): Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.

Why pay more for prescriptions?

Use Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply from a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. Call ahead to determine which pharmacy provides the most competitive price.

Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive alternative that serves the same purpose as prescription medications.

Need to see a doctor on demand?

Telehealth Services

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet, video chat or telephone. By leveraging these virtual visits, you can avoid emergency rooms or urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

If your telehealth doctor prescribes you medication, BlueCare Anywhere will ensure you are able to conveniently pick up your prescription in your local area. You may also use mail-order services for delivery of your prescription.

The copay for medical visits is $10 and counseling or psychiatry visits is $20 with the PPO plans. HDHP plan participants are subject to the deductible and coinsurance.

Start your eVisit today!

- Online: bluecareanywhereaz.com
- Download BlueCare Anywhere's mobile app

"I need specific medical care! How much does it cost?"

Plan Highlights	HDHP $3,000	PPO $1,500
	In-network	In-network
Annual Calendar Year Deductible		
Individual	$3,000	$1,500
Family	$6,000	$3,000
Maximum Calendar Year Out-of-pocket [1]		
Individual	$3,500	$2,500
Family	$7,000	$5,000
Professional Services		
Primary Care Physician (PCP)	10% after deductible	$25 copay
Specialist	10% after deductible	$45 copay
Telehealth Visit	10% after deductible	$10 copay /$20 copay
Preventive Care Exam	No charge	No charge
Diagnostic X-ray and Lab	10% after deductible	Office visit copay or 20% after deductible
Complex Diagnostics (MRI/CT Scan)	10% after deductible	Office visit copay or 20% after deductible
Chiropractic Services	10% after deductible	$45 copay
Hospital Services		
Inpatient	10% after deductible	20% after deductible
Outpatient Surgery	10% after deductible	20% after deductible
Urgent Care	10% after deductible	$75 copay
Emergency Room	10% after deductible	$200 copay
Mental Health & Substance Abuse		
Inpatient	10% after deductible	20% after deductible
Outpatient	10% after deductible	Office visit copay or 20% after deductible
Retail Prescription Drugs (30-day supply)		
Tier 1	$10 copay after deductible	$15 copay
Tier 2	$20 copay after deductible	$35 copay
Tier 3	$40 copay after deductible	$65 copay
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$20 copay after deductible	$30 copay
Tier 2	$40 copay after deductible	$70 copay
Tier 3	$80 copay after deductible	$130 copay

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

“I need specific medical care! How much does it cost?”

Plan Highlights	PPO $500	PPO $300
	In-network	In-network
Annual Calendar Year Deductible		
Individual	$500	$300
Family	$1,000	$600
Maximum Calendar Year Out-of-pocket (1)		
Individual	$1,500	$1,000
Family	$3,000	$2,000
Professional Services		
Primary Care Physician (PCP)	$20 copay	$15 copay
Specialist	$40 copay	$25 copay
Telehealth Visit	$10 copay /$20 copay	$10 copay /$20 copay
Preventive Care Exam	No charge	No charge
Diagnostic X-ray and Lab	Office visit copay or 10% after deductible	Office visit copay or 10% after deductible
Complex Diagnostics (MRI/CT Scan)	Office visit copay or 10% after deductible	Office visit copay or 10% after deductible
Chiropractic Services	$40 copay	$25 copay
Hospital Services		
Inpatient	10% after deductible	10% after deductible
Outpatient Surgery	10% after deductible	10% after deductible
Urgent Care	$50 copay	$25 copay
Emergency Room	$150 copay	$100 copay
Mental Health & Substance Abuse		
Inpatient	10% after deductible	10% after deductible
Outpatient	Office visit copay or 10% after deductible	Office visit copay or 10% after deductible
Retail Prescription Drugs (30-day supply)		
Tier 1	$15 copay	$10 copay
Tier 2	$25 copay	$20 copay
Tier 3	$50 copay	$40 copay
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$30 copay	$20 copay
Tier 2	$50 copay	$40 copay
Tier 3	$100 copay	$80 copay

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Employee Wellness

Employee Wellness

A healthier you starts here – mind and body!

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual healthcare costs. We care about your total well-being and encourage all employees to engage in our wellness resources at no-cost.

Wellness Program

BCBSAZ Sharecare

BCBSAZ Sharecare Wellness Program includes a variety of educational resources and opportunities for participation throughout the year. Employees and their dependents that voluntarily participate and successfully complete certain wellness related activities become eligible to win great prizes.

Take Control of Your Health

Blue Cross® Blue Shield® of Arizona has partnered with Sharecare, an award-winning digital health solution, to provide you simple tools to manage all your health and wellness needs in one place. You'll start by taking the RealAge health assessment to get a measure of the true age of your body in terms of health and vitality, versus your calendar age. The program then delivers personalized insights, challenges, daily tracking, and one-of-a-kind tools to help you reduce your RealAge and live healthier, no matter where you are in your health journey. Learn what you need to be healthier with tips on how to eat better, exercise smarter, reduce stress, and more. The Sharecare app recommends simple things you can do every day, and reminds you to do them.

Manage your health and reduce your RealAge:

- Take the RealAge test: The RealAge health assessment calculates your body's true age in terms of health and vitality.
- Manage your health profile: One convenient location with all your essential health information, including your
- prescriptions, medical conditions, and test results.
- Get personalized recommendations: Challenges, tips, articles, and videos based on your health needs as identified in your RealAge test
- Results.
- Stay supported and motivated: Expert guidance and accountability when you need it, with achievable goals and rewards to help you lower your RealAge.
- Feel Secure: Sharecare keeps your account private and secure. You own your health data, and you decide whom you want to share it with.

Find out your RealAge today! azblue.sharecare.com

Spending Accounts

Spending Accounts

Make your money work for you.

Health Savings Account (HSA)

By enrolling in the BCBSAZ $3,000 HDHP (High-Deductible Health Plan), you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified healthcare expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What to know about your Health Savings Account

What to know about your Health Savings Account

What are the benefits?	• HSA funds can grow on a tax-free basis, subject to state law. Please consult your tax advisor for applicable tax laws in your state. • An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified healthcare expenses (tax regulations vary by state). • You may enjoy lower monthly premium payments on your High-Deductible Health Plan (HDHP) as compared to a traditional PPO medical plan.
How do I become eligible to contribute to an HSA?	• You become eligible to contribute to an HSA if you are covered under a HDHP, you are not enrolled in non-qualified health insurance outside of Tohono O'odham Nation's plan, you are not enrolled in Medicare, you are not claimed as a dependent on someone else's tax return (excluding a spouse), you have not received any hospital care or medical services from IHS or the Veterans Administration, in the last three months (unless these services were related to a service-connected disability) and you are not enrolled in a general Healthcare Flexible Spending Account (Health FSA) or a general Health Reimbursement Arrangement (HRA).
How do I get started?	• The most convenient way to pay for qualified expenses is to utilize the debit card. You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account. It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS. • Once the HSA account is activated, you can manage and access your account at any time by visiting www.HealthEquity.com. If questions arise regarding account activation, contact HealthEquity or visit www.HealthEquity.com. Consult your tax advisor for taxation information or advice.
A few rules to keep in mind…	• For 2023, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $3,850 if you are enrolled in the HSA-PPO for employee-only coverage, and $7,750 for employees with dependent coverage. • It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax. Enrolled employees are able to monitor deductions through the iSolved portal under "Pay History". • There is a 20% penalty for using HSA funds on non-qualified healthcare expenses if you are under age 65. For more details about what is considered a qualified healthcare expense, visit www.irs.gov. • Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon the maximum annual contribution limit for that calendar year, multiplied by the **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would be eligible to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first becomes HSA eligible on September 1st of that applicable year. However, under the Full-Contribution Rule, an employee is allowed to contribute the maximum annual contribution amount to his/her/their HSA, regardless of the number of months he/she/they were eligible to contribute to an HSA in that year, if he/she/they are eligible to contribute to an HSA on December 1 of the year and continues to be eligible to contribute to an HSA until December 31st of the following year (i.e., for all subsequent days until December 31st of the following year).

(1) Please consult your tax advisor for applicable tax laws in your state.

Supplemental Health Plans

Supplemental Health Plans

Be prepared for the unexpected.

Critical Illness Coverage

Critical illness coverage offered on a voluntary basis through Symetra pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

What can critical illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance
- Lost income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to a specialist

What are examples of covered illnesses or conditions?

- Cancer
- Heart Attack
- Stroke
- Kidney Failure
- Organ Transplant

100% Employee-paid

If you elect the voluntary critical illness plan, 100% of the cost is deducted through payroll deductions.

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$10,000, $15,000 or $20,000 (All Guaranteed Issue)
Spouse	50% of Employee benefit election (All Guaranteed Issue)
Child(ren)	25% of Employee benefit election (All Guaranteed Issue)

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information or to obtain a full schedule of benefits contact Human Resources.

Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital insurance offered on a voluntary basis through Symetra pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

How can hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Child care
- Lodging expenses for a companion
- Lost income

Here's an example of how Hospital Insurance works

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5 day hospital stay. Through his primary medical insurance, Trevor owed a $500 deductible and $3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a $1,000 admission benefit plus $150 for each additional day, he was only out of pocket $1,900 instead of $3,500.

Out-of-Pocket Expenses	Hospital Indemnity Plan Benefits
$500 deductible	$1,000 admission benefit
$3,000 co-insurance	$150/day x 4 additional days = $600
Total: $3,500	**Total benefits paid to Trevor: $1,600**

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary hospital insurance plan, 100% of the cost is deducted through payroll deductions.

Monthly post-tax rates are outlined below:

Election	Monthly Contribution Plan 1	Monthly Contribution Plan 2
Employee Only	$13.56	$17.41
Employee + Spouse	$28.91	$37.11
Employee + Child(ren)	$22.23	$28.55
Family	$40.25	$51.67

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information or to obtain a full schedule of benefits contact Human Resources.

Accident Insurance Plan

Accident insurance offered on a voluntary basis through Symetra provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

How can accident insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

What are some common covered benefits?

- Emergency room visit
- Ambulance
- Doctor visits
- Hospital admission
- Surgery
- Medical equipment
- Outpatient therapy
- Diagnostic imaging

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$300
Emergency room care	$150
Physician follow-up ($75 x 2)	$150
X-ray	$50
Concussion	$150
Broken tooth (repaired by crown)	$300
Total benefit paid by Kathy's Accident Plan	**$1,100**

Here's an example of how Accident Insurance can help support you

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive $1,100 to help pay for Molly's expenses associated with her accident.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary accident insurance plan, 100% of the cost is deducted through payroll deductions.

Monthly post-tax rates are outlined below:

Election	Monthly Contribution Plan 1	Monthly Contribution Plan 2	Monthly Contribution Plan 3
Employee Only	$6.11	$9.56	$12.50
Employee + Spouse	$10.51	$16.75	$22.01
Employee + Child(ren)	$11.58	$20.94	$27.71
Family	$15.60	$29.74	$39.40

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information or to obtain a full schedule of benefits contact Human Resources.


Dental
Plan

Dental Plan

A smile is the nicest thing you can wear.

Using the HMO Plan

You and your enrolled eligible dependents must first select a primary care dentist who participates in the Cigna DHMO network. To receive benefits in the Dental HMO plan, your primary care dentist must provide the service or refer you to a specialist. If you receive services from any other dentist, you would be responsible for paying the entire dental bill yourself. In order to receive dental coverage when using an HMO, it's important that you determine whether the dental office is in a network that your insurance covers. To confirm you've found a dentist in the right network, visit mycigna.com and search the Cigna DHMO network or call Cigna.

Using the PPO Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. To determine whether your dentist is in or out of your insurance network, go to mycigna.com and search the Cigna DPPO network, or call Cigna.

"I need specific dental care! How much does it cost?"

Plan Highlights	Dental HMO	Dental PPO Medium		Dental PPO High	
	In-network Only	In-network	Out-of-network	In-network	Out-of-network
Calendar Year Deductible					
Individual	None	$50	$50	$50	$50
Family	None	$150	$150	$150	$150
Annual Maximum	None	$1,500	$1,500	$2,000	$2,000
Preventive	$5 office visit copay	0% no deductible	0% no deductible	0% no deductible	0% no deductible
Basic Services	See Charge Schedule	20% after deductible	20% after deductible	10% after deductible	10% after deductible
Major Services	See Charge Schedule	50% after deductible	50% after deductible	40% after deductible	40% after deductible
Orthodontia Services					
Adult	See Charge Schedule	Not covered	Not covered	Covered at 50%	Covered at 50%
Child up to age 19	See Charge Schedule	Covered at 50%	Covered at 50%	Covered at 50%	Covered at 50%
Lifetime Maximum	N/A	$1,500	$1,500	$2,000	$2,000

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Vision Plan

Vision Plan

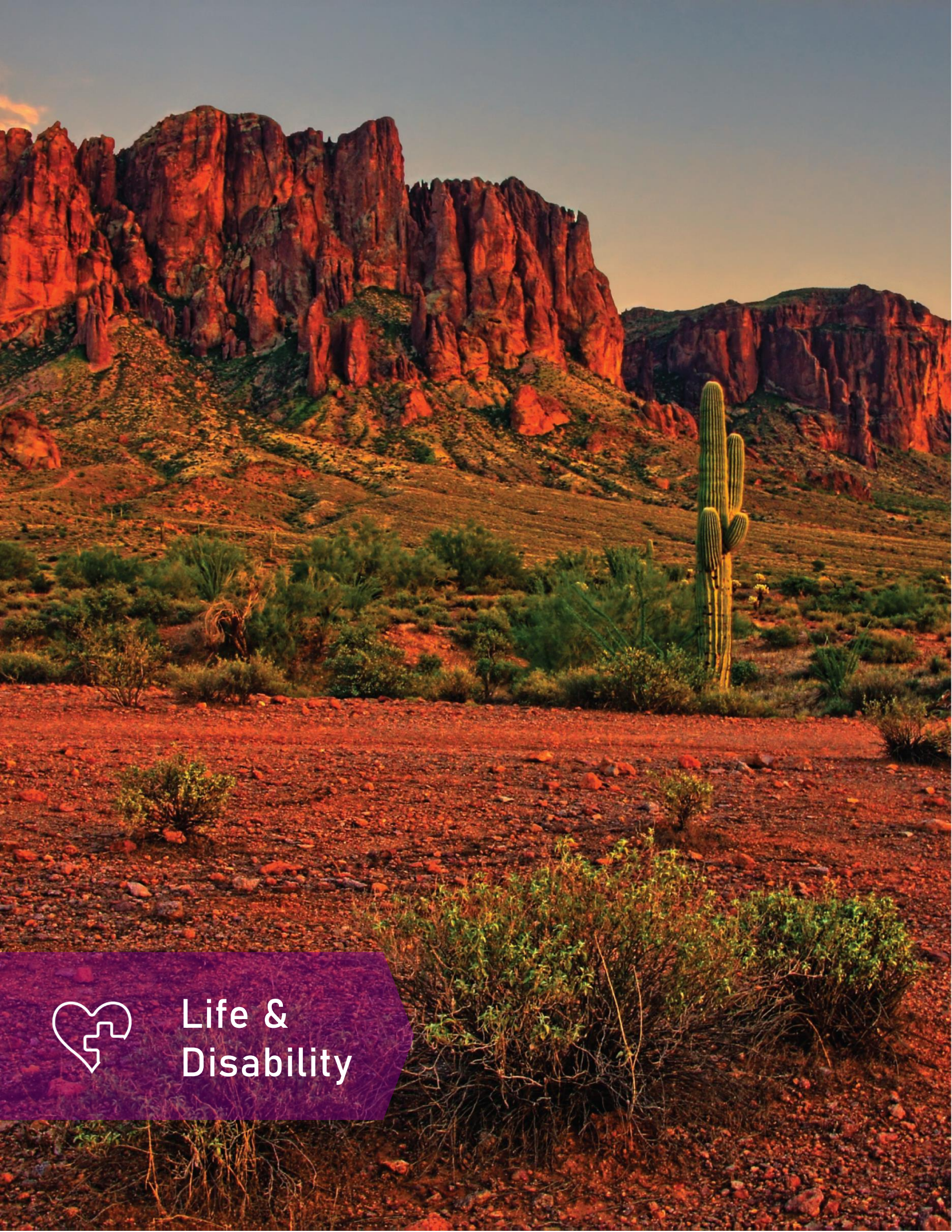
Keep a clear focus on your sight.

Vision coverage is offered by Cigna as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit mycigna.com.

"I need specific vision care! How much does it cost?"

Plan Highlights	Cigna Vision PPO Medium	Cigna Vision PPO Premier
	In-network	In-network
Exam	**Every 12 months**	**Every 12 months**
Exam copay	$20 copay	$10 copay
Lenses	**Every 12 months**	**Every 12 months**
Single	$20 copay	$10 copay
Bifocal	$20 copay	$10 copay
Trifocal	$20 copay	$10 copay
Frames	**Every 24 months**	**Every 12 months**
Frame Allowance	$130 allowance + 20% off overage	$180 allowance + 20% off overage
Contacts, in lieu of lenses & frames	**Every 12 months**	**Every 12 months**
Medically Necessary	Covered 100%	Covered 100%
Elective	$130 allowance	$180 allowance

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.


Life &
Disability

Life & Disability

Protection for your loved ones.

Basic Life and AD&D

In the event of your passing, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your accidental death & dismemberment (AD&D) coverage may apply.

Paid for in full by Tohono O'odham Nation, the benefits outlined below are provided by New York Life:

- Basic Life Insurance of $75,000.
- AD&D of $75,000.
- Please note, benefits may reduce when you reach age 70.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional life and AD&D coverage for you and your dependents is available on a voluntary basis through payroll deductions from New York Life.

For employees:	Increments of $10,000 up to the lesser of 5x your annual salary or $500,000 with a guarantee issue benefit of $150,000 if you enroll in the plan within 30 days of your initial eligibility.
For your spouse:	Increments of $5,000 up to the lesser of $250,000 or 50% of your elected amount with a guarantee issue benefit of $25,000 if you enroll in the plan within 30 days of your initial eligibility.
For your child(ren):	14 days old up to age 26, $5,000 or $10,000.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves. If you were previously enrolled in the Voluntary Life and AD&D plan through New York Life, you may increase your coverage by $10,000 annually up to the guaranteed issue amount at re-enrollment without providing EOI.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 70. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Required!
Are your beneficiaries up to date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time.
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.
- To select or change your beneficiary, contact Human Resources.

Short & Long Term Disability

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD) Employer Paid	• Administered by New York Life, STD coverage provides a benefit equal to 60% of your earnings, up to $2,500 per week for a period up to 26 weeks. • The plan begins paying these benefits after you have been absent from work for 14 consecutive days.
Long Term Disability (LTD) Employer Paid	• If your disability extends beyond 180 days, the LTD coverage through New York Life can replace 60% of your earnings, up to maximum of $10,000 per month. • Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.

Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.

Tax considerations

Because disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.

Please note: Consult your tax advisor for additional taxation information or advice.

Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

Your free and confidential go-to resource.

We can all use an extra helping hand from time to time. Whether you need support with a personal relationship or professional challenge, or you're seeking guidance on a particular subject, the Employee Assistance Program (EAP) provides the tools you need to thrive. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Number of sessions	3 face-to-face sessions per year per member per incident
How to access	Phone or face-to-face sessions
Topics may include	Mental Health Support: • Marital, relationship or family problems. • Bereavement or grief counseling. • Substance abuse and recovery. Community Support: • Childcare and eldercare. • Legal services and Identity theft. • Financial support. • Educational materials.
Who can utilize	All employees, dependents of employees, and members of your household

Get in touch:

- By phone: 877.622.4327
- Online: cignabehavioral.com
- Employer ID: Tohono

Perks & More

Perks & More

Let's cover the fun stuff.

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

Pet Insurance

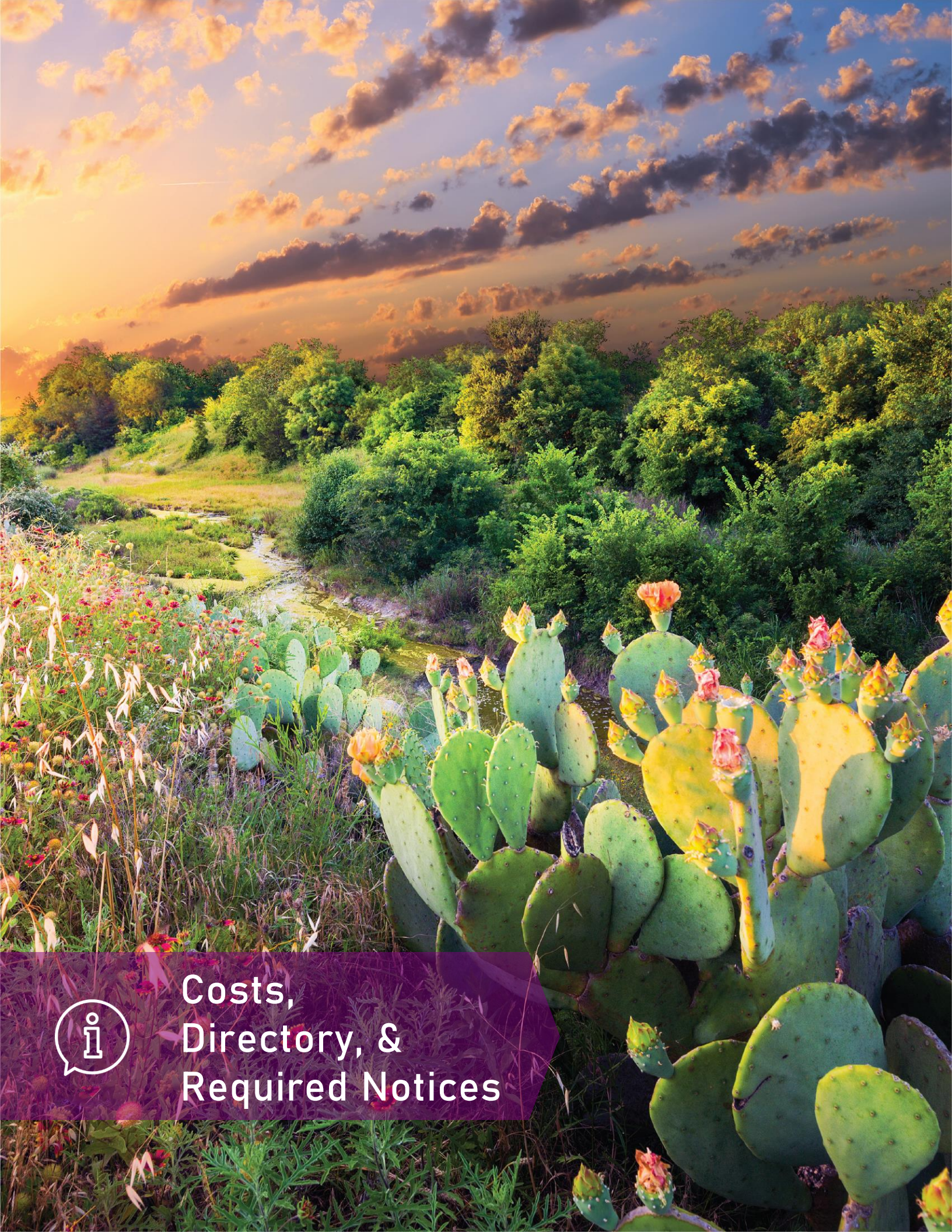
For many of us, our pets are just as special and loved as our family members. That's why it's important we protect their health too! Our pet insurance benefit, offered by Nationwide, covers dogs, cats, birds, and some exotic animals. Check out the plans on Nationwide's website at petinsurance.com or contact them to discuss the best coverage for your animal.

Legal Services

When you need guidance on personal legal matters, Hyatt Legal's services can provide you with access to a network of qualified attorneys. Whether you prefer telephonic or in-office consultation, you may receive guidance on topics such as debt matters, family law, preparation of wills, real estate matters, trusts, and more. Coverage for business or employment related legal concerns may not be offered. To learn more or begin coverage, contact Human Resources.

Identity Theft

Tohono O'odham Nation offers protection for its employees from the hardships associated with identity theft. Through Info Armor, employees can purchase industry-leading identity protection and fraud detection services on an individual basis, or for their families. To learn more or begin coverage, contact Human Resources.



Costs, Directory, & Required Notices

Cost Breakdown

All of your rates in one place.

The rates below are effective October 1, 2023 - September 30, 2024.

Coverage Level	Total Cost	Contribution	Payroll Deduction
	Monthly	Tohono O'odham Nation Monthly	Employee Biweekly
BCBS HDHP $3,000			
Employee Only	$526.99	$526.99	$0.00
Employee + 1 Dependent	$1,095.58	$925.00	$78.73
Employee + 2 or More Dependents	$1,291.32	$1,050.00	$111.38
BCBS PPO $1,500			
Employee Only	$654.06	$654.06	$0.00
Employee + 1 Dependent	$1,359.74	$925.00	$200.65
Employee + 2 or More Dependents	$1,602.69	$1,050.00	$255.09
BCBS PPO $500			
Employee Only	$795.48	$654.06	$65.27
Employee + 1 Dependent	$1,653.75	$925.00	$336.35
Employee + 2 or More Dependents	$1,949.22	$1,050.00	$415.02
BCBS PPO $300			
Employee Only	$831.66	$654.06	$81.97
Employee + 1 Dependent	$1,728.96	$925.00	$371.06
Employee + 2 or More Dependents	$2,037.87	$1,050.00	$455.94
Cigna Dental HMO Plan			
Employee Only	$6.65	$6.65	$0.00
Employee + 1 Dependent	$9.97	$9.97	$0.00
Employee + 2 or More Dependents	$15.05	$15.05	$0.00
Cigna Dental PPO Medium Plan			
Employee Only	$24.93	$4.62	$6.89
Employee + 1 Dependent	$44.88	$6.92	$13.79
Employee + 2 or More Dependents	$83.44	$9.23	$29.28
Cigna Dental PPO High Plan			
Employee Only	$28.87	$4.61	$8.71
Employee + 1 Dependent	$51.96	$6.92	$17.06
Employee + 2 or More Dependents	$90.52	$9.23	$32.55
Cigna Vision Medium Plan			
Employee Only	$5.20	$0.00	$2.40
Employee + 1 Dependent	$9.93	$0.00	$4.58
Employee + 2 or More Dependents	$16.15	$0.00	$7.45
Cigna Vision Premier Plan			
Employee Only	$8.61	$0.00	$3.97
Employee + 1 Dependent	$16.45	$0.00	$7.59
Employee + 2 or More Dependents	$26.75	$0.00	$12.35

Directory & Resources

Below, please find important contact information and resources for Tohono O'odham Nation.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources		520.383.6540	HRBenefits@tonation-nsn.gov
Online Enrollment Vendor: • isolved			myisolved.com
Medical Coverage			
BlueCross BlueShield of AZ	010986	866.422.2729	www.azblue.com
Health Savings Account			
HealthEquity		866.346.5800	www.healthequity.com
Supplemental Health			
Symetra	12543000	800.796.3872	www.symetra.com
Dental Coverage			
Cigna	3341001	800.244.6224	www.mycigna.com
Vision Coverage			
Cigna	3341001	877.478.7557	www.mycigna.com
Life, AD&D and Disability			
New York Life • Basic Life • Voluntary Life • Basic and Voluntary AD&D • Short Term Disability • Long Term Disability	 FLX966088 FLX966100 OK969410 LK751594 LK964180	800.225.5695	www.newyorklife.com
Employee Assistance Plan			
Cigna	3341001	877.622.4327	cignabehavioral.com Employer ID: Tohono
Pet Insurance			
Nationwide		800.540.2016	www.petinsurance.com
Legal Services			
Hyatt Legal		800.821.6400	www.legalplans.com
Identity Theft			
InfoArmor	1792	800.789.2720	www.infoarmor.com
Benefits Broker / Claims Questions			
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC Claims Advocate - Shan O'Connor		602.385.7069	soconnor@lovitt-touche.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Medicare Part D
Creditable Coverage Notice

Important Notice from Tohono O'odham Nation
About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan while enrolled in Tohono O'odham Nation coverage as an active employee, please note that your Tohono O'odham Nation coverage will be the primary payer

for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Tohono O'odham Nation coverage as a former employee.

You may also choose to drop your Tohono O'odham Nation coverage. If you do decide to join a Medicare drug plan and drop your current Tohono O'odham Nation coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Tohono O'odham Nation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2023
Name of Entity/Sender: Tohono O'odham Nation
Contact--Position/Office: Sharon Standifer, Human Resources Manager
Address: P.O. Box 837 Sells, Arizona 85634
Phone Number: 520-383-6540

Medicare Part D
Non-Creditable Coverage Notice

Important Notice from Tohono O'odham Nation About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tohono O'odham Nation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Tohono O'odham Nation has determined that the prescription drug coverage offered by the Tohono O'odham Nation is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [Insert Name of Plan]. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. **You can keep your current coverage from Tohono O'odham Nation. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are**

covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with Tohono O'odham Nation, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Tohono O'odham Nation.

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

If you decide to join a Medicare drug plan while enrolled in Tohono O'odham Nation coverage as an active employee, please note that your Tohono O'odham Nation coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Tohono O'odham Nation coverage as a former employee.

You may also choose to drop your Tohono O'odham Nation coverage. If you do decide to join a Medicare drug plan and drop your current Tohono O'odham Nation coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under Tohono O'odham Nation is not creditable, you may pay a penalty to join a Medicare drug plan depending on how long you go without creditable prescription drug coverage. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2023
Name of Entity/Sender: Tohono O'odham Nation
Contact--Position/Office: Sharon Standifer, Human Resources Manager
Address: P.O. Box 837 Sells, Arizona 85634
Phone Number: 520-383-6540

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Tohono O'odham Nation group health coverage 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 you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Sharon Standifer, Human Resources Manager, at 520-383-6540 ext 12722.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Tohono O'odham Nation sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Tohono O'odham Nation, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Tohono O'odham Nation, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Tohono O'odham Nation HIPAA Privacy Officer:

Tohono O'odham Nation
Attention: HIPAA Privacy Officer
Sharon Standifer

Effective Date

This Notice as revised is effective October 1, 2023.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period Tohono O'odham Nation has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 520-383-6540

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed

later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: TON Human Resources

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect

COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Please contact TON Human Resources

HIPAA Notice of Availability of Notice of Privacy Practices

The Tohono O'odham Nation Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact TON Human Resources.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

Notice Regarding Availability of Health Insurance Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(Expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Tohono O'odham Nation		4. Employer Identification Number (EIN) 86-0044545
5. Employer address Main Street		6. Employer phone number 520-383-6450
7. City Sells	8. State AZ	9. ZIP Code 85634
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above) Click here to enter text.		12. Email address HRBenefits@tonation-nsn.gov

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are:

  Full-time regular employees working 20 hours or more per week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Your legal Spouse or domestic partner (with affidavit), and dependent eligible children (up to age 26) or older who are or become disabled and dependent upon the employee.

  ☐ We do not offer coverage.

- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Notes

Prepared by: Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC
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