Inspiring Every Child to Achieve

PHOENIX #1
Elementary School District








Phoenix #1

Employee Benefits Guide

School Year 2024-2025

We Care

Health + Wellness

Thrive Together

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FIRST CLASS BENEFITS AT PHOENIX #1

We work hard to make sure you have the best care and resources to thrive!

Introduction

Whether you are a new employee enrolling for the first time or considering your benefits during open enrollment, this guide is designed to help you through the process.

Phoenix #1 is proud to offer a benefits package that includes medical, dental, and vision insurance coverage for you and your dependents.

Please take the time to read this information and ask questions so you can make the best benefit decisions for you and your family.

If you should have any questions:

Contact Crystal Senesy, Benefits and Wellness Supervisor, directly.
602-257-6075 or Crystal.senesy@phxschools.org.

This booklet highlights important features of Phoenix #1 benefits for benefit eligible employees.

ENROLLMENT INFORMATION

Annual Open Enrollment

Open Enrollment is limited to May 1st through May 31st each year.

All benefit eligible employees are required to elect coverage via iVisions. Any coverage not actively selected will be considered a waiver of coverage.

New Employees

New Employees have 31 days from hire date to complete enrollment in the group insurance program. If you have moved from a non-benefit's eligible status to a benefits eligible status, you will have 31 days to complete your enrollment. All insurance coverage starts the first of the month.

Remember, if elections are not made within the 31-day initial period of eligibility, you will be required to wait until Annual Open Enrollment or until a Qualifying Life Event takes place.

Pre-Tax Deductions

Our medical plans are IRS Section 125 which allow your deductions to be deducted pre-tax. Participation in a Section 125 Plan is on an annual basis. Your insurance premiums are paid with money removed from your gross wages prior to any tax calculations. This reduces your tax liability and is a more efficient way to pay for premiums.

Qualifying Life Event

The elections that you make during Open Enrollment or at initial benefits eligibility will remain in effect for the plan year (July 1 - June 30). During that time, if your life or family status changes according to the recognized events listed below, you are permitted to revise your benefits coverage to accommodate your new status. You may make benefits changes by contacting the Benefits Department and providing the proper documentation.

QUALIFYING LIFE EVENTS LIST

Marital Status Changes

- Marriage
- Death of spouse
- Divorce
- Spouse employer's Open Enrollment
- Spouse gains or loses coverage from another source

Covered Dependent Changes

- Birth or adoption of a child
- Dependent becomes ineligible for coverage
- Death of dependent child

IRS regulations govern under what circumstances you may make changes to your benefits, which benefits you can change and what kind of changes are permitted.

- All changes must be consistent with the qualifying event.
- In most cases, you cannot change your benefit plan, but may modify the level of your coverage (in other words, you can add or delete dependents, enroll or disenroll yourself or dependents, but not switch insurance carriers or plans).

Any changes in benefit levels must be completed within 31 days of the qualifying life event.

COBRA

In most cases, if your employment ends, benefits will terminate on the last day of the month in which you worked.

COBRA is for continuation of benefits when an employee leaves the District's active medical and dental plans. Coverage will continue to be provided, but the employee will assume the entire monthly premium plus an addition 2% P&A administration fee. The District currently pays the premium amount for the employee's standard coverage. COBRA is provided through P&A, our third-party administrator. Your monthly premiums are due to P&A by their due date and coverage will be cancelled by P&A if not received on time. ASRS Retirees need to stop by the Benefits Office to complete a form to participate in the supplemental benefits plan.

Below is a step-by-step guide on how to elect COBRA coverage and submit premiums. Please carefully review what's required of you when electing COBRA coverage.

STEP 1: Your employer will first need to notify P&A Group of your termination.

STEP 2: Once P&A Group has received your termination information, your COBRA election packet will be generated within 5-7 business days from the date of receipt.

STEP 3: Your COBRA election packet will then be mailed out to you via USPS. Depending on the delivery time for USPS, this typically takes anywhere from 7-10 business days from the time P&A Group places the packet in the mail.

STEP 4: Once you receive your COBRA election packet, you must complete the forms and send them back via one of the methods below.

HOW TO ELECT COBRA

To elect COBRA continuation coverage, please reference the process outlined above. **Under federal law, you have 60 days after the date of this notice or when your coverage ceases, whichever is later, to elect COBRA continuation coverage.** The post mark date will be provided in your COBRA election packet. If you do not submit your election by this date, you will lose your right to elect COBRA continuation coverage.

HOW TO SUBMIT YOUR COBRA FORMS

Choose from one of the options below to submit your completed COBRA election forms.

MAIL: P&A Group, Attn: COBRA Department
17 Court Street, Suite 500
Buffalo, N.Y. 14202

EMAIL*: COBRA@padmin.com

FAX*: (716) 855-7107

*If you e-mail or fax your COBRA election packet, please keep in mind you will still need to pay your premiums in order for your coverage to be effective. See payment options below.

HOW TO SUBMIT YOUR COBRA PAYMENT

Choose from one of the options below to submit your COBRA payment.

MAIL: P&A Group, Attn: COBRA Department
17 Court Street, Suite 500
Buffalo, N.Y. 14202

IVR: (800) 688-2611; follow the telephone prompts.

ONLINE: Create an online account at padmin.com. In the login box, select "Participant" under User Type and "COBRA" under Account Type. Once you log in, go to Member Tools in the tool bar and select "Make Payment."

Payments made online or by phone will be available 24 hours after we receive and process your COBRA election packet.

PARTICIPANT SUPPORT CENTER

For assistance with any payment options, please contact our Participant Support Center by phone or online web chat.

HOURS: Monday - Friday, 8:30 a.m. - 10:00 p.m. ET.
PHONE: (716) 852-2611
LIVE CHAT: www.padmin.com (click "Chat" at the top of the page.)

Terms to understand

What is a deductible?

A deductible is the amount you have to pay for covered health care services before your health plan starts to pay. Most plans do not require you to pay a deductible for certain covered preventive care services if they are received in the network.

Do I really have to pay the full cost of the covered health care services before I meet the deductible?

Yes. You will pay for all covered health care services until you reach your deductible. You can use a health savings account (HSA) to help pay or you can save it to use later. Using network providers can help lower your cost.

What is coinsurance?

After you've paid your deductible, you only pay a percentage of the cost for each covered service, called coinsurance (e.g., your plan pays 80% and you pay 20%).

What is an out-of-pocket limit?

The out-of-pocket limit is the most you have to pay for covered services in a plan year. If your deductible and coinsurance payments reach the out-of-pocket limit, your plan will pay 100% of allowed amounts for covered services for the rest of the year.

Specifics of the plan

Why does the plan have a high deductible?

To open and put money into an HSA, you must have a high deductible health plan. This is one of the rules set by the Internal Revenue Service (IRS). This type of plan is meant to help you take a more active role in your health care buying decisions.

How is this plan different from a copayment plan?

Most traditional copayment plans focus on managing your health benefits. This plan focuses on managing your health by encouraging you to:

- Take a more active role in your health care buying decisions
- Make more informed choices and seek quality care
- Open an HSA, which you can't get with a traditional plan

Can I see any doctor I want? Why am I asked to use network providers?

Yes, you can see any doctor you want. You are encouraged to use health care providers in the network because they've agreed to charge lower prices. For example, when you use a network doctor, you'll usually pay less compared to one who is not in the network.

Do I need to choose a primary care provider (PCP) and get a referral to see a specialist?

No. You have the freedom to use any doctor or hospital without being required to choose a PCP or get referrals.

Are emergency room and urgent care services covered?

Yes, emergency room and urgent care services are covered.

Can I cover my children and other dependents under this plan?

Yes, adult children are eligible for coverage under the plan up to age 26. Dependents younger than 19 cannot be denied coverage because of a pre-existing medical condition.

Access your benefits and get help anytime, anywhere

It's **myuhc.com®** in your pocket.
With the UnitedHealthcare® app, you can:

- Access your health plan ID card
- Check claim updates
- Find providers and facilities
- Estimate costs

INSURANCE CONTACTS/INFO.

United Health Care- Medical

Group # 927878

Register on https://member.uhc.com/myuhc to look up In-Network Providers for your plan/Estimate Cost's for Services/Claims/Request a new card

***New Hires can visit www.whyuhc.com to compare plans and search for providers in all 3 plans**

UHC Customer Service Phone #'s

Choice Plus HDHP 1-866-314-0335
Doctors Plan 1-844-376-0313
Choice Plus Buy-Up 1-866-633-2446

Delta Dental of Arizona- Dental

Group # 04693

1-800-352-6132

Register on https://www.deltadentalaz.com/ to look up In-Network Providers/Claims/Request a card.

**Insurance card is not needed for services; provider can look up benefits with DOB and SS#*

EyeMed/Delta Vision of AZ- Vision

Group # 9688037

1-866-605-4242

Register on https://eyemed.com/en-us to look up In-Network Providers/Request a card

**Insurance card is not needed for services; provider can look up benefits with DOB and SS#*

Optum Bank- Health Savings Accounts (HSA)

1-800-243-5543

Email: accountholderservices@optum.com

Register on https://www.optumbank.com/ to view your account/order new cards/submit claims/etc.

P&A- Flexible Spending Account (FSA)/Dependent Care Account (DCA)

1-800-688-2611

Register on https://padmin.com/ to view your account/order new cards/submit

Jorgensen Brooks Group- Employee Assistance Program (EAP)

1-888-520-5400 or 1-520-575-8623

Call 24 hours/7 days https://jorgensenbrooks.com/

Symetra- Supplemental Life Insurance/Short-Term Disability

1-800-426-7784

https://www.symetra.com/

Arizona State Retirement System- Long Term Disability

1-800-621-3778

https://www.azasrs.gov/

EMPLOYEE/DEPENDENT INSURANCE RATES
FOR FISCAL YEAR 2024/2025
EFFECTIVE 7/1/2024 – 6/30/2025

United Health Care HDHP $3,000	Employee Monthly Premium	Seasonal Employees Per Pay Deduction 21 pays	12 Month Employees Per Pay Deduction 26 pays	COBRA Monthly Premium
Employee Only	$0.00	$0.00	$0.00	$554.52
Employee + 1	$513.45	$293.40	$236.98	$1,109.05
Employee + 2/More	$703.43	$401.96	$324.66	$1,314.23
HSA District Contribution $1,000 Yearly	$83.34	$47.62	$38.47	N/A
United Health Care PPO Narrow	Employee Monthly Premium	Seasonal Employees Per Pay Deduction 21 pays	12 Month Employees Per Pay Deduction 26 pays	COBRA Monthly Premium
Employee Only	$0.00	$0.00	$0.00	$614.67
Employee + 1	$569.14	$325.23	$262.68	$1,229.33
Employee + 2/More	$779.74	$445.57	$359.88	$1,456.77
United Health Care Buy-Up	Employee Monthly Premium	Seasonal Employees Per Pay Deduction 21 pays	12 Month Employees Per Pay Deduction 26 pays	COBRA Monthly Premium
Employee Only	$50.75	$29.00	$23.43	$669.47
Employee + 1	$670.65	$383.23	$309.54	$1,338.94
Employee + 2/More	$900.02	$514.30	$415.40	$1,586.65

Delta Dental	Employee Monthly Premium	Seasonal Employees Per Pay Deduction 21 pays	12 Month Employees Per Pay Deduction 26 pays	COBRA Monthly Premium
Employee Only	$20.00	$11.43	$9.24	$35.36
Employee + 1	$58.48	$33.42	$27.00	$73.84
Employee + 2/More	$103.62	$59.22	$47.83	$118.98

Delta Vision Voluntary Vision Plan	Employee Monthly Premium	Seasonal Employees Per Pay Deduction 21 pays	12 Month Employees Per Pay Deduction 26 pays	COBRA Monthly Premium
Employee Only	$6.19	$3.54	$2.86	$6.19
Employee + 1	$12.51	$7.15	$5.78	$12.51
Employee + 2/More	$21.93	$12.54	$10.13	$21.93

You will have deductions for 26 paydays (12-month employees) or 21 paydays (all seasonal employees) for fiscal year 2024/2025. Payday amount = Monthly amount x 12 months/26 or 21 paydays. **The payday amounts will be different for mid-year hires/changes; payday amount will equal the monthly amount multiplied by the number of months from the effective date through 6/30/25 divided by the number of paydays left to deduct for fiscal year 2024/2025.**

COBRA is for continuation of benefits when an employee leaves the District's active medical and dental plans. Coverage will continue to be provided, but the employee will assume the entire monthly premium plus an additional 2% P&A administration fee; The District currently pays the premium amount for the employee's standard coverage. COBRA is provided through P&A, our third-party administrator. Your monthly premiums are due to P&A by their due date and coverage will be cancelled by P&A if not received on time. ASRS Retirees need to stop by the Benefits Office to complete a form to participate in the supplemental benefits plan.

Our medical plans are IRS Section 125 plans, which allow your deductions to be deducted pre-tax. Participation in Section 125 plans is on an annual basis. An employee is not allowed to change his/her election during the plan year. You will not be able to make changes to this plan year's election until the next annual open enrollment or during certain qualifying events. **All enrollments/cancellations must be processed within 31 days of the qualifying event.**

Review your plan coverage details

Health Plan Coverage	Buy Up		Doctor's Plan		HDHP $3,000	
Deductibles and Out-of-Pocket Limits	**In-Network**	**Out-of- Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Amounts						
Individual	$1,500	$3,000	$1,000	$3,000	$3,200	$6,000
Family	$3,000	$6,000	$2,000	$6,000	$6,400	$12,000
Out-of-Pocket Limits						
Individual	$3,500	$8,000	$3,500	$8,000	$6,400	$10,000
Family	$7,000	$16,000	$7,000	$16,000	$12,800	$20,000
Medical Copays and Coinsurance						
Doctors and Specialists						
Preventative Care Visit	$0	50%*	$0	50%*	$0	50%*
Primary Care Visit (Illness or Injury)	$25	50%*	$0	50%*	20%*	50%*
Virtual Visit (Online Doctor)						
Urgent Care Visit	$75	50%*	$0	50%*	20%*	50%*
Specialist Visit	$50	50%*	$75	50%*	20%*	50%*
Lab and X-Ray	$25	50%*	20%*	50%*	20%*	50%*
Major Diagnostic & Imagining	$250	50%*	20%*	50%*	20%*	50%*
Emergency Care						
Emergency Room	$300	$300	$300	$300	20%*	20%*
Emergency Transportation	20% *	20%*	20% *	20%*	20%*	20%*
Other Care						
Mental Health Visit (Outpatient)	$25	50%*	$0	50%*	20%*	50%*
Mental Health Visit (Inpatient)	20%*	50%*	20%*	50%*	20%*	50%*
Surgery-Outpatient	20%*	50%*	20%*	50%*	20%*	50%*
Hospital-Inpatient Stay	20%*	50%*	20%*	50%*	20%*	50%*
Physician fees for surgical and medical services	20%*	50%*	20%*	50%*	20%*	50%*

Pharmacy Copays	Retail	Out-of-Network	Home Delivery (up to 30 day supply)	Retail	Out-of-Network	Home Delivery (up to 30 day supply)	Retail	Out-of-Network	Home Delivery (up to 30 day supply)
Prescription Type									
Tier Level 1	$5	$5	$12.50	$5	$5	$12.50	$5*	$5*	$12.5*
Tier Level 2	$40	$40	$100	$40	$40	$100	$40*	$40*	$100*
Tier Level 3	$105	$105	$262.50	$105	$105	$262.50	$105*	$105*	$262.5*
Tier Level 4	$250	$250	$625	$250	$250	$625	$250*	$250*	$625*

*After the Deductible

**Tier Level 4 Pharmacy Copay Specialisty Medications $500

Questions about your health plan? We've got answers.

Help is just a call away

Whether you have questions about a new claim, need to find a doctor or just want to better understand your benefits, our Advocates are here to help. Connect with our team for help finding care for your needs, walking through a bill, accessing additional plan resources and more.

We simplify the health care experience to help you:

- Understand your benefits and claims
- Learn more about your prescriptions*
- Get answers about a bill or payment
- Find support if you have a child with complex needs**
- Locate care and cost options
- Discover your plan's health and well-being benefits

We're dedicated to giving you the information you need to get the most out of your benefits— and your health.

Care whenever you need it

Try 24/7 Virtual Visits to speak with a doctor anytime, from virtually anywhere, using a mobile device or computer. To get started, sign in at **myuhc.com®.**

Connect with us

Call the number on your health plan ID card or sign in to **myuhc.com** and click on **Call** or **Chat**

United Healthcare

*For members with OptumRx®.

**Qualifying members are eligible for our Special Needs Initiative program; eligibility criteria can be determined by calling the number on your health plan ID card.

This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the program is for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The program is not an insurance company and may be discontinued at any time. Additionally, if there is any difference between the information and your coverage documents (Summary Plan Description, Schedule of Benefits, and any attached Riders and/or Amendments), your coverage documents govern.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Get to know your care options and costs

How much you pay for care can depend on where you get it — and a great place to start may be with your PCP. For serious or life-threatening conditions, call 911 or go to an emergency room.

Care options to consider and approximate costs	START HERE **PCP** Care from the doctor who may know you best	**24/7 Virtual Visits** See a doctor whenever, wherever	**Convenience care** Basic conditions that aren't generally life-threatening	**Urgent care** Serious conditions that aren't generally life-threatening	**Emergency room** Life- and limb-threatening emergencies
Average cost*	**$160**	**Less than $49****	**$100**	**$180**	**$2,200**
Hours	**Varies by location**	**24/7**	**Varies by location**	**Varies by location — may be open nights/ weekends**	**24/7**
How to connect	**Contact your PCP**	**myuhc.com/virtualvisits**	**myuhc.com®**	**myuhc.com**	**myuhc.com**
✔ **indicates the recommended place for care for the following common conditions:**					
Broken bone				✔	✔
Chest pain					✔
Cough	✔	✔	✔		
Fever	✔	✔	✔		
Muscle strain	✔		✔		
Pinkeye	✔	✔	✔		
Shortness of breath					✔
Sinus problems	✔	✔	✔		
Sore throat	✔	✔	✔		
Sprain	✔		✔	✔	
Urinary tract infection	✔	✔	✔		

Did you know?

Emergency rooms are likely the most expensive place to get care. When you need to be seen, consider the chart above to help you find care. If you're still unsure about what's best for your situation, sign in to **myuhc.com** > **Find Care & Costs** to locate a network provider or call the member phone number on your ID card for support. If you have a question about what's covered by your plan, visit **myuhc.com** > **Coverage & Benefits** for answers.

*Source 2019: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated $2,000.00 difference between the average emergency room visit, $2,200 and the average urgent care visit $180.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

**The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

Check your official health plan documents to see what services and providers are covered by your plan.

Simple ways to help you save

Here are a few good-to-know things you can do to help get more out of your health plan.

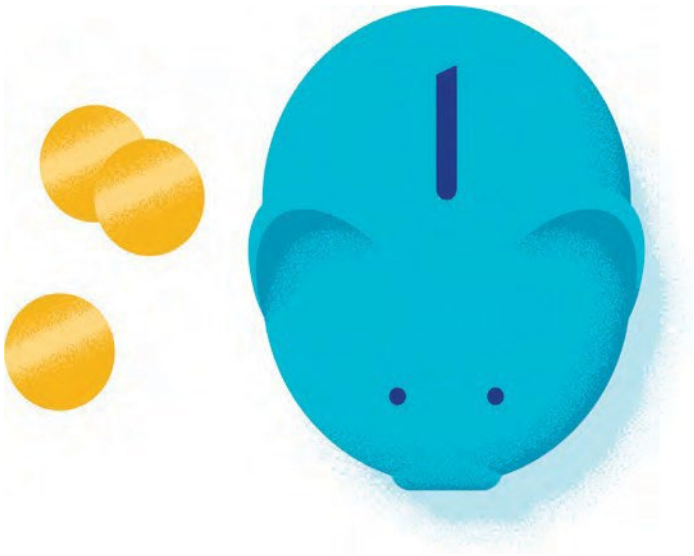
Stay in the network

The doctors and facilities in the network may have agreed to provide services at a discount — so staying in network makes sense, especially when visiting an out-of-network provider could end up costing you a lot more for care or may not be covered at all. Sign in to **myuhc.com** > **Find Care & Costs** to locate:

- Labs
- Hospitals
- Mental health professionals
- Network providers

Look up the cost of medication

Sign in to **myuhc.com** > **Pharmacies & Prescriptions** to find information about your medication, pricing and lower-cost options.



Shop around

With such a wide variety of services, from minor procedures to major surgeries, it's a good idea to check approximate pricing first. Visit **myuhc.com** > **Find Care & Costs** to view average costs.

See your plan in action

Watch your personalized video for another way to understand your coverage, out-of-pocket costs and how your plan* works. Watch (and re-watch) anytime by signing in to **myuhc.com** > **Coverage & Benefits.**

*Information will vary to reflect your actual coverage. Members with a Health Incentive Account are not eligible for the video.

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $49 or less.[3]**

Consider 24/7 Virtual Visits for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$49 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit—bringing a potential $2,000[4] cost down to $49.

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

[4] Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on $131 difference between average Urgent Care visit cost of $180 and Virtual Visit cost of $49; $2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

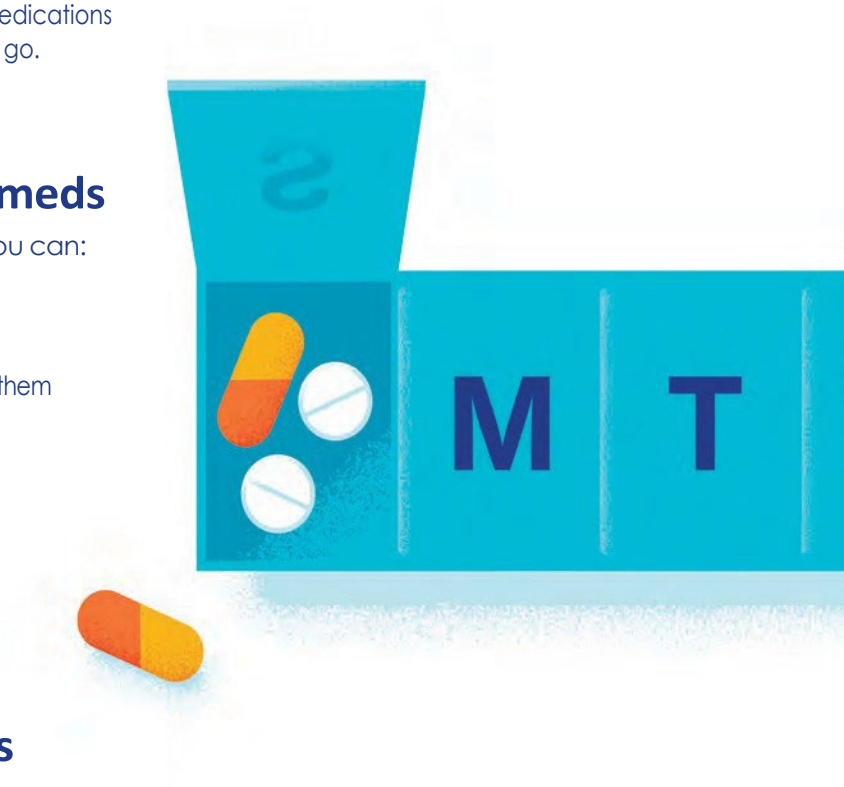
The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

Say hello to OptumRx

OptumRx® pharmacy services help make it easier to save on medications and keep track of them, too — whether you're online or on the go.



More ways to help manage your meds

When you go to **myuhc.com** > **Pharmacies & Prescriptions** you can:

- Find and compare medication costs
- Locate a network pharmacy
- See if your medications have any requirements before filling them

Two ways to fill your prescriptions

Use home delivery

Order a 3-month supply through OptumRx and you may pay less for medication, get standard shipping at no cost and save trips to the pharmacy. Sign up on **myuhc.com,** use the UnitedHealthcare app or call the member phone number on your ID card. Make sure you have at least a 1-month supply to cover you through the transition.

*Not all prescriptions are eligible for home delivery.

Pick up at the pharmacy

Use your ID card at any network pharmacy. You can find network pharmacies at **myuhc.com**, on the UnitedHealthcare app or by calling the member phone number on your ID card.

Keep costs in check

Your Prescription Drug List (PDL) — available on **myuhc.com** — lists the most commonly prescribed medications covered by your plan. Choosing medications in the lower tiers may help you save money. And, consider generic medications instead of brand names which may keep costs down.

When life gets challenging, you've got caring, confidential help

Your Employee Assistance Program (EAP) provides support and resources to help you, and your family, with a range of issues, including:

- Managing stress, anxiety and depression
- Improving relationships at home or work
- Getting guidance on legal and financial concerns
- Coping with occupational stress and burnout support
- Addressing substance use issues

This service is provided to you at no additional cost.

$0

Call today for access to EAP resources at no additional cost

EAP provides coverage for 3 free counseling sessions per incident, per year.

Services are completely confidential and will not be shared with your employer.

Get started – call EAP 24/7 at **1-888-887-4114**

United Healthcare

Get in on UHC Rewards

Good news—your health plan comes with a way to earn up to $300. UnitedHealthcare Rewards is included in your health plan at no additional cost.

There's so much good to get

With UHC Rewards, a variety of actions—including things you may already be doing, like tracking your steps or sleep—lead to rewards. The activities you go for are up to you, and the same goes for ways to spend your earnings.

Here are just a few of the ways you can earn:

Earn up to $300

Connect a tracker	**$25**
Take a health survey	**$15**
Get an annual checkup	**$25**
Get a biometric screening	**$50**

Visit UHC Rewards for the full list of rewardable activities that are available to you—and look for new ways of earning rewards to be added throughout the year.

continued

United Healthcare

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you—and start earning

Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to $300 for completing rewardable activities

Questions?

Call customer service at **1-866-230-2505**

United Healthcare

One Pass Select™

Rediscover your passion for health

With One Pass Select, we're on a mission to make fitness engaging for everyone. One Pass Select can help you reach your fitness goals, while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. Choose a membership tier that fits your lifestyle and provides everything you need for whole body health in one easy, affordable plan

You and your eligible family members (18+) can get started with One Pass Select when you activate UnitedHealthcare Rewards. Plus, you can use your earnings to help pay for your One Pass Select membership.

Find your fit with One Pass Select

At the gym

Choose from our large nationwide network of gym brands and local fitness studios. Use any gym in the network and create a routine just for you.

At home

Work out at home with live or on-demand online fitness classes. Try our workout builder to get routines created just for you, no matter what your fitness level and interests are.

$29/Mo

Classic

12,000+ gym locations

$64/Mo

Standard

13,000+ gym and premium locations

$99/Mo

Premium

16,000+ gym and premium locations

$144/Mo

Elite

18,000+ gym and premium locations

An enrollment fee may apply.

Or get started with a digital-only plan for $10/Mo.

To get started:

1. Scan this code to download the **UnitedHealthcare® app**
2. Sign in or register
3. Select **UHC Rewards**
4. Select **Redeem rewards** to access One Pass Select

United Healthcare

One Pass Select is a voluntary program featuring a subscription based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If anyfraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or as the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico nor available to level funded members in District of Columbia, Hawaii, Vermont and Puerto Rico.

SafeTrip™

Get the protection you need for the trip you want. Sign up for SafeTrip travel protection before leaving for your next travel destination. SafeTrip plans provide medical insurance coverage of up to $1 million, access to medical and travel assistance services, medical evacuation, and lost or delayed baggage reimbursement – and all for as little as the cost of a family meal.

You'll be protected during a work trip, family visit or vacation getaway

Insurance Benefits

- Available medical coverage amounts of $100,000; $500,000; and $1 million
- Medical evacuation (up to $1 million)
- Emergency reunion with family
- Return of dependent children
- Baggage loss and/or delay
- Loss of life or limb
- Repatriation of remains
- Optional trip cancellation with trip interruption
- Optional extreme sports coverage
- Your choice of three deductible amounts

Medical Assistance Services

- Assistance accessing a network of more than 1 million care providers worldwide
- Treatment monitoring
- Medication and vaccine transfer coordination
- Replacement of corrective lenses and medical devices
- Dispatch of medical specialists
- Medical records transfer
- Regular and ongoing communication with family and other key contacts
- Arrangements for hotel convalescence

Travel Assistance Services

- Flight and hotel arrangements
- Support for lost or stolen travel documents

UnitedHealthcare® Global

How to Enroll with SafeTrip

By your side, Worldwide.

- Visit **uhcsafetrip.com**.
- **Provide the requested trip details,** such as destination, number of travelers and dates.
- **Compare plan options,** coverage amounts, deductibles and prices.
- **Select the plan** and options that best meet your needs.
- **Review the policy document** to understand how to use your plan, and how pre-existing conditions, pregnancy, sports injuries and dental issues are covered.
- **Medical protection** plans can be purchased **up to the day before you leave** on your trip.
- Trip cancellation with trip interruption must be purchased **at least 10 days prior** to departure.
- **Questions?** Call us at **+1.800.732.5309**.

Why Buy Travel Protection?

One in six Americans have had their travel plans impacted by accident, medical conditions, natural disasters, or other events. 78 percent of those travelers did not have insurance.

Reduce your risk and go home healthy. With SafeTrip, you'll have a defense when it comes to high medical costs, language barriers, lost travel documents and the uncertainty of not having a resource for medical or non-medical crises. And it's all from a name you trust – UnitedHealthcare Global.

[1] Source: US Travel Insurance Association January 2014

How to Use Your SafeTrip Benefits

1. Always **carry your ID card** with you while traveling.
2. If you have a **medical or travel problem**, call UnitedHealthcare Global's Emergency Response Center at the number on your ID card. **Call the toll-free number for the country you are in.**
3. If you are in a country not listed, call the **Emergency Response Center** collect at **+1.410.453.6330**. A multilingual coordinator will immediately assist you and will monitor your case until the situation is resolved.

Reduce risk and increase happiness with SafeTrip. Visit us at uhcsafetrip.com

UnitedHealthcare® Global

Opening an HSA

What is a health savings account or HSA?

An HSA is a bank account that lets people put money aside, income tax-free, to save and pay for qualified medical expenses. It's a real bank account, but you don't pay federal income tax on the money you deposit into it or the money you use for qualified medical expenses. You can even build your savings into a nest egg for retirement.

What are the requirements for opening an HSA?

To deposit money into an HSA, you must be enrolled in an HSA-qualifying health plan.

You are eligible if:

- You are covered under a qualified high deductible health plan
- You are covered by no other health coverage, unless it is permissible coverage
- You are not enrolled in Medicare
- You cannot be claimed as a dependent on someone else's tax return

Some other restrictions apply. Please talk to a tax, benefits or financial advisor if you have more questions.

Can I open an HSA if I have a health care flexible spending account (FSA)?

No. All of the money in your health care FSA must be spent before you can open an HSA.

Is it OK if I wait to open my HSA?

It's important to open and make a deposit into your HSA as soon as the plan year starts. That way, you will be prepared if you need to pay or reimburse yourself for any services early in the year. If you have any expenses before you open your HSA, you can't use your HSA to reimburse yourself later.

If my spouse is on Medicare, can I open and contribute to an HSA?

Yes. If a spouse will be or is already covered by Medicare, you can sign up for this plan and open and contribute to an HSA. If you file taxes jointly with your spouse, you can use your HSA to help pay for your spouse's qualified expenses, such as Medicare premiums.

What is a qualified medical expense?

According to the IRS, a qualified medical expense is a health care service or item that would qualify for a tax deduction. This means you can use an HSA to pay for these expenses and without paying taxes on them. Go to **irs.gov** to learn more about which expenses can be paid with an HSA.

What expenses don't qualify for tax benefits?

Examples of expenses that do not qualify include cosmetic surgery, health club memberships, teeth whitening and over-the-counter medicines purchased without a prescription. If you use an HSA to pay for an expense that is not qualified, you will have to pay taxes on the expense and may also have to pay a 20% penalty.

Can I use any bank?

Yes. You can open your HSA with any bank of your choice. Optum Bank® is your employer's preferred health care bank and a national leader in HSA banking.

I still have money in my health care FSA. Can I open an HSA?

No. All of the money in your health care FSA must be spent before you can open an HSA.

Using an HSA

Is there a limit on how much I can put into my HSA each year?

Yes. The IRS limits how much you (and others) can put into an HSA each year.

The 2022 limits are:

- $3,650 for individual coverage
- $7,300 for family coverage

If you are 55 or older, you can deposit an extra $1,000 during the year. This is called a catch-up contribution. Any contributions above these limits are subject to income taxes and a penalty.

Do I have to pay federal taxes on the money I deposit into an HSA?

When you deposit money into an HSA, you won't have to pay federal income tax on:

- Deposits you or others make into your HSA
- Money you spend from your HSA on qualified expenses
- Interest earned from the HSA

What happens if I leave my current employer, change health plans or retire?

The money in your HSA is yours to keep. If you leave your company, change health plans or retire, you take your HSA with you. If you switch to a health plan that makes you ineligible to continue depositing money in an HSA, you may continue to use the money in your account for qualified medical expenses, but you can no longer make deposits.

Contributing to an HSA

If my spouse has his or her own health plan with an HSA, can I also contribute to it?

Yes, but the IRS says the two of you together can only contribute up to the family limit. Both of you can contribute to just one of your HSAs, or you can contribute to both HSAs as long as the total amount doesn't go above the annual family limit.

I want my HSA dollars to go as far as possible. How can I find out how much a treatment or procedure is going to cost?

After you enroll, you will have tools on **myuhc.com** that can help you estimate the cost of treatments and other procedures based on your health plan, a specific doctor or hospital and your ZIP code.

How do I pay with an HSA?

If you receive a bill from your doctor or if you are paying for a prescription, you can pay from your HSA using your HSA debit card or checks provided by your bank.

If I paid a health care bill with my credit card, can I pay myself back from my HSA?

Yes, as long as the service is a qualified expense. You can take money out of your HSA to pay yourself back with no penalty. Receipts should be retained.

Can I use the HSA for my spouse or dependents if they're not covered under my plan?

You can use the HSA to pay for qualified expenses of any family member if they are claimed as a spouse or dependent on your taxes. If a tax dependent is not covered under your plan, and you use your HSA to pay for their expenses, those expenses will not go toward your deductible.

If I am covering an adult child, can I use my HSA to help pay for his or her qualified medical expenses?

Your child must be a tax dependent to use your HSA. If your child is not a tax dependent, but is covered by your plan, he or she may be able to open his or her own HSA.

If I'm 65 or older and decide to retire, what happens to my HSA?

After you turn 65 or start receiving Medicare benefits, you may withdraw money from your HSA for medical and non-medical purposes without penalty. When your Medicare coverage starts, you can use your HSA to pay your Medicare premiums, deductibles and copayments.

If I cover my domestic partner under my plan, can I use my HSA for my partner's medical expenses?

If your domestic partner meets the IRS qualifications of a tax dependent, you can use your HSA to help pay his or her qualified expenses. If your partner is not a tax dependent, you can still cover your partner under your plan. However, your partner would need to open and fund his or her own HSA to pay for the expenses.

Can I have an HSA and a health care flexible spending account (FSA)?

No. If you are enrolled in a health care FSA, the IRS will not allow you to open an HSA. But the law does permit you to enroll in a limited-purpose FSA if it is offered to you. A limited-purpose FSA can only be used to pay for eligible dental and vision expenses.

Can other people put money into my HSA?

Yes, anyone can contribute to your HSA.

Contact your UnitedHealthcare representative for more information

United Healthcare

Delta Dental PPO plus Premier™
Summary of Benefits
for Group# 4693-10001000, 10002000, 19901000
Phoenix Elementary School District

This Summary Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Group – Phoenix Elementary School District

Benefit Year – January 1 through December 31

Deductible – $50 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, X-rays, periodontal maintenance, and orthodontic services.

Benefit Maximum Payment – $2,000 per person total per Benefit Year on all services, except TMD treatment and orthodontic services. $1,500 per person total per lifetime on orthodontic services. $2,000 per person total per lifetime on TMD treatment.

Dependent Age Limit – To age 26

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Periodontal Maintenance – cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Emergency Palliative Treatment – to temporarily relieve pain	80%	80%	80%
Sealants – to prevent decay of permanent teeth	80%	80%	80%
Minor Restorative Services – fillings	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Major Restorative Services – crowns	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
TMD Treatment – treatment of the disorder of the temporomandibular joint	50%	50%	50%
Major Services			
Crown Repair – to individual crowns	60%	60%	60%
Relines and Repairs – to bridges and dentures	60%	60%	60%
Prosthodontic Services – bridges, implants, and dentures	60%	60%	60%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Treatment for Dependent Children must begin on or after age 8 and banded prior to age 17.	Treatment for Dependent Children must begin on or after age 8 and banded prior to age 17.	Treatment for Dependent Children must begin on or after age 8 and banded prior to age 17.

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

Frequencies and Limitations

- Oral exams are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Scaling (equivalent to one cleaning) is payable once in any two-year period. Full mouth debridement (equivalent to one cleaning) is payable once in any five-year period.
- Fluoride treatments are payable twice per calendar year for people age 17 and under.
- Sealants are payable once per tooth in any three-year period for bicuspids and first and second molars for people age 18 and under. The surface must be free from decay and restorations. Preventive resin restoration on molars is payable once per lifetime for people age 15 and under with moderate to high caries risk. Treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament is payable twice per tooth per calendar year for people age 18 and under.
- Bitewing X-rays are payable twice per calendar year. Full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Space maintainers and recement or rebond of space maintainers are payable once per area per lifetime for people age 13 and under. Distal shoe space maintainers are payable once per area per lifetime for people age eight and under.
- Endodontic treatment is payable once per tooth per lifetime. Endodontic retreatment is payable once per tooth in any three-year period.
- Root planing and scaling is payable once per quadrant in any two-year period. Only two quadrants of root planing and scaling can be performed on the same day.
- Implants bound by natural teeth and prefabricated and custom fabricated abutments are payable once per tooth per lifetime and subject to a $1,000 maximum per tooth. Implant-related services are payable.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are payable.
- Silver amalgam and, for front teeth only, composite resin restorations are payable once per surface in any two-year period. Composite resin restorations are optioned treatment on posterior teeth.
- Inlays (any material) are payable.
- Porcelain and resin facings on crowns are optioned treatment.
- Crowns and onlays and associated procedures (cores, substructures) are payable once per tooth in any five-year period.
- Oral surgery, including simple and surgical extractions, is payable. TMD treatment is payable.
- Fabrication of athletic mouthguard is payable once in any two-year period for people age 17 and under. Occlusal guards are not payable.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a treatment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon treatment plan, Delta Dental will make an initial payment to you or your Participating Dentist upon insertion of the appliances or initial banding, equal to 50% of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services as set forth in this Summary of Benefits. Provided Member has current eligibility on the date of service 12 months from the date the appliances or initial banding were placed, Delta Dental will make an additional payment equal to the balance of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services. Maximum Payment for Orthodontic Services equals the lesser of Delta Dental's total Copayment for Orthodontic Services, the Maximum Payment per person total per lifetime on orthodontic services or the fee charged by your provider for orthodontic services.

Deductible Carry Forward – Any expenses incurred by an eligible person for covered services during the last three months of a benefit year and applied to the Deductible for that benefit year will also be applied to the Deductible for the following Benefit Year.

Eligible People – As defined by the Employer Group. The Group pays the full cost of this plan for Subscribers. The Subscriber pays the additional cost of dependent coverage.

Dual Spouse – If you and your Spouse are both eligible to enroll in this Dental Plan as Subscribers, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Subscribers under this Dental Plan.

Coverage ends at the end of the month that the Subscriber and/or Dependent is no longer eligible.

Delta Dental PPO plus Premier™
Resumen de Beneficios
Para el grupo 4693-10001000, 10002000, 19901000
Phoenix Elementary School District

Se debe leer el presente Resumen de beneficios junto con su Certificado. El certificado proporciona información adicional sobre su plan de Delta Dental, incluso información sobre las exclusiones y limitaciones del plan. Si alguna declaración en el presente resumen entra en conflicto con una declaración en el certificado, la declaración en el presente se aplica a usted y se debe ignorar la declaración en conflicto en el certificado. Los porcentajes que se indican a continuación se aplican a la asignación de Delta Dental para cada servicio y pueden variar según la participación del dentista en la red de proveedores*.

Grupo: Distrito escolar de Phoenix Elementary School District

Año de beneficios: 1 de enero hasta el 31 de diciembre

Deducible: total de $50 por persona por año de beneficios, limitado a un deducible máximo de $150 por familia por año de beneficios.
El deducible no se aplica a los exámenes orales, servicios de prevención, rayos X, selladores, mantenimiento periodontal y servicios de ortodoncia.

Pago máximo de beneficios: total de $2.000 por persona por año de beneficios en todos los servicios, excepto el tratamiento de DTM (TMD por sus siglas en inglés) y los servicios de ortodoncia. Pago total de $1.500 por persona por vida en los servicios de ortodoncia. Pago total de $2.000 por vida en el tratamiento de DTM.

Límite de edad para dependientes: hasta los 26 años

Servicios cubiertos:

	Dentista Delta Dental PPO™	Dentista Delta Dental Premier®	Dentista No participante
	El plan paga	El plan paga	El plan paga*
Diagnóstico y Prevención			
Servicios de diagnóstico y prevención: exámenes, limpiezas, fluoruro y mantenedores de espacio	100%	100%	100%
Radiografías: rayos X	100%	100%	100%
Mantenimiento periodontal: limpiezas después de la terapia periodontal	100%	100%	100%
Servicios Básicos			
Tratamiento paliativo de emergencia: para aliviar temporalmente el dolor	80%	80%	80%
Selladores: para impedir las caries en los dientes permanentes	80%	80%	80%
Servicios: restaurativos menores: empastes [rellenos]	80%	80%	80%
Servicios de endodoncia: tratamiento de conducto	80%	80%	80%
Servicios de periodoncia: tratamiento de la enfermedad de las encías	80%	80%	80%
Servicios de cirugía oral: extracciones y cirugía dental	80%	80%	80%
Servicios complejos de restauración: coronas			
Otros servicios básicos: servicios varios	80%	80%	80%
Tratamiento de DTM: tratamiento para la disfunción de la articulación temporomandibular	50%	50%	50%

Servicios Complejos			
Reparación de corona: a coronas individuales	60%	60%	60%
Reforrado y reparaciones: a puentes y dentaduras postizas	60%	60%	60%
Servicios de prostodoncia: puentes, implantes y dentaduras postizas	60%	60%	60%
Servicios de Ortodoncia			
Servicios de ortodoncia: aparatos ortodóncicos [frenos]	50%	50%	50%
Límite de edad para el beneficio de ortodoncia:	El tratamiento para los menores de edad dependientes debe comenzar a partir o después de los 8 años y se deben colocar las bandas antes de los 17 años.	El tratamiento para los menores de edad dependientes debe comenzar a partir o después de los 8 años y se deben colocar las bandas antes de los 17 años.	El tratamiento para los menores de edad dependientes debe comenzar a partir o después de los 8 años y se deben colocar las bandas antes de los 17 años.

* Cuando usted recibe servicios de un dentista no participante, los porcentajes en esta columna indican la parte que se pagará por Delta Dental por esos servicios, según la Tabla de cuotas aprobadas para los dentistas no participantes. La cuota aprobada para dentistas no participantes puede ser inferior a lo que cobra el dentista y usted es responsable de pagar esa diferencia.

Frecuencias y limitaciones

- Los exámenes orales se pagan dos veces por año calendario.
- Las profilaxis (limpiezas) se pagan dos veces por año calendario. La eliminación del sarro (equivalente a una limpieza) se paga una vez en cualquier período de dos años. El desbridamiento bucal completo (equivalente a una limpieza) se paga una vez en cualquier período de cinco años.
- Los tratamientos con fluoruro se pagan dos veces por año calendario para personas menores de 17 años.
- Los selladores se pagan una vez por diente en cualquier período de tres años para las bicúspides y los molares primeros y segundos para las personas menores de 18 años. La superficie debe estar libre de caries y restauraciones. La restauración preventiva de la resina en los molares se paga una vez por vida para las personas menores de 15 años con riesgo de caries de moderado a alto. El tratamiento de una lesión cariosa activa y no sintomática mediante la aplicación tópica de un medicamento que detiene o inhibe la caries se paga dos veces por diente por año calendario para personas menores de 18 años.
- Las radiografías interproximales (en inglés *bitewing*) se pagan dos veces por año calendario. Los rayos X de boca completa (que incluyen rayos X interproximales) o un panorex se pagan una vez en cualquier período de tres años.
- Los mantenedores del espacio y el proceso de volver a cementar o pegar los mantenedores del espacio son pagaderos una vez por área por vida para las personas menores de 13 años. Los mantenedores de espacio distal tipo zapato son pagaderos una vez por área por vida para las personas menores de 8 años.
- El tratamiento endodóntico se paga una vez por diente por vida. El retratamiento endodóntico se paga una vez por diente en cualquier período de tres años.
- El alisado y raspado radicular se paga una vez por cuadrante en cualquier período de dos años. Solo se permite realizar el alisado y raspado radicular de dos cuadrantes en el mismo día.
- Los implantes unidos por dientes naturales y los pilares prefabricados y fabricados a medida se pagan una vez por diente por vida y están sujetos a un máximo de $1.000 por diente. Los servicios relacionados con el implante son pagaderos.
- Las coronas sobre los implantes se pagan una vez por diente en cualquier período de cinco años. Los servicios relacionados con las coronas sobre implantes son pagaderos.
- Las amalgamas de plata y, para los dientes delanteros solamente, las restauraciones de resina compuesta se pagan una vez por superficie en cualquier período de dos años. Las restauraciones de resina compuesta son opciones de tratamiento en los dientes posteriores.
- Las incrustaciones [en inglés, *inlays*] de cualquier material son pagaderas.
- Las capas exteriores de porcelana y resina en coronas son opciones de tratamiento.
- Las coronas, los onlays y los procedimientos asociados con ello (núcleos, subestructuras) se pagan una vez por diente en cualquier período de cinco años.
- Se paga la cirugía oral, incluso las extracciones simples y quirúrgicas. El tratamiento de DTM (en inglés, TMD) es pagable.

- La fabricación del protector bucal atlético se paga una vez en cualquier período de dos años para personas menores de 18 años. No se pagan los protectores oclusales.

Pago por los servicios de ortodoncia: al comenzar el tratamiento ortodóntico, su dentista presentará un plan de tratamiento a Delta Dental basado en el curso proyectado del tratamiento. De acuerdo con el plan de tratamiento acordado, Delta Dental realizará un pago inicial a usted o a su dentista participante tras la colocación inicial de los aparatos o las bandas, igual al 50% del copago enumerado en la tabla de Delta Dental sobre el pago máximo por servicios de ortodoncia, como se establece en el presente resumen de beneficios. Siempre que el miembro tenga elegibilidad actual en la fecha de servicio 12 meses a partir de la fecha en que se colocaron los aparatos o bandas iniciales, Delta Dental realizará un pago adicional igual al saldo del copago máximo enumerado en la tabla de Delta Dental de servicios de ortodoncia. El pago máximo por servicios de ortodoncia será igual al menor de lo siguiente: o la cantidad total de copago de Delta Dental por servicios de ortodoncia, o el pago máximo total de por vida por persona en servicios de ortodoncia, o la cuota que cobra su proveedor por los servicios de ortodoncia.

Traslado del deducible: Cualquier gasto incurrido por una persona elegible por servicios cubiertos durante los últimos tres meses de un año de beneficios y asignado al deducible para dicho año, también se trasladará al deducible para el siguiente año de beneficios.

Personas elegibles: según lo definido por el Grupo de empleador(es). El Grupo paga el costo total de este plan para los suscriptores. El suscriptor titular pagará el costo adicional para la cobertura de dependientes.

Doble cónyuges: Si usted y su cónyuge son elegibles para inscribirse en este plan dental como suscriptores titulares del seguro, ustedes pueden ser inscritos juntos en una solicitud o por separado en solicitudes individuales, pero no en ambas. Sus hijos dependientes solo pueden ser inscritos bajo una solicitud. Delta Dental no coordinará los beneficios entre la cobertura de usted y la cobertura de su cónyuge si usted y su cónyuge están cubiertos como titulares del seguro bajo este plan dental.

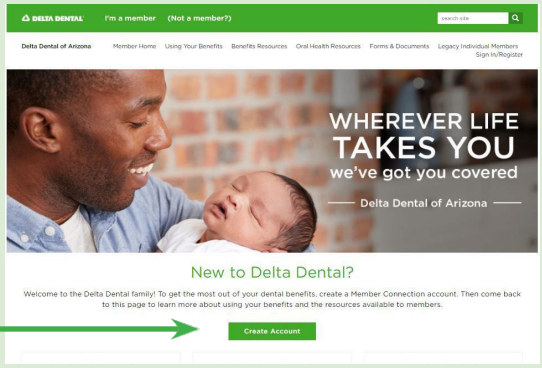
La cobertura termina al final del mes en que el Suscriptor titular del seguro y/o Dependiente ya no son elegibles.

Register for the Member Portal

1

Go to deltadentalaz.com/member and click **Create Account**

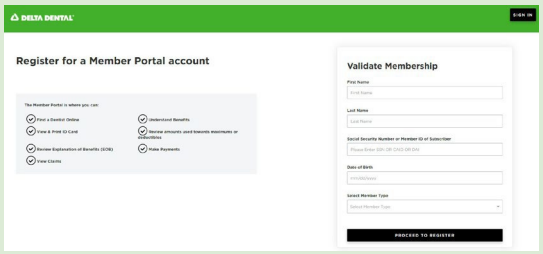
Note: Please wait 48 hours after your effective date to register for the member portal.



2

Validate your membership:

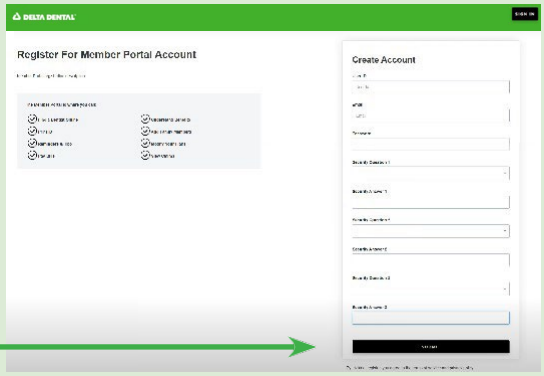
- Enter your first and last name
- Enter the primary enrollee's member ID or social security number
- Enter your date of birth
- Select the member type that applies to you
- Click **Proceed to register**



3

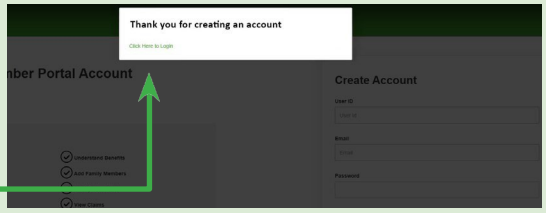
Create your account:

- Choose a user ID and password
- Enter your email address
- Select 3 challenge questions in case you forget your password
- Click **Submit**



4

You have successfully created your account. Follow the prompt to login using your new user ID and password.



Once registered, you can easily access benefits and claims information, print a temporary ID card, search for a dentist, set paperless preferences, view EOB history and more.

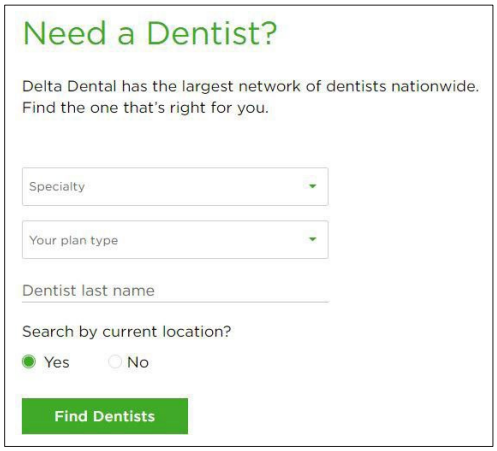
Finding a Network Dentist

Delta Dental of Arizona has the largest dentist network in the state. With nearly 90% of Arizona's practicing dentists enrolled, it's very likely your dentist is in the Delta Dental network.[1] Nationally, Delta Dental also boasts the largest network, giving members more than 155,000 dentists to choose from.[2]

On the Web

It's easy to find a Delta Dental dentist near you with our provider search tool:

1. Go to **deltadentalaz.com/find**
2. Choose a specialty and your plan type from the drop-down menus
3. In the Search By Current Location question, choose **Yes** or **No**



   - **Yes** – The tool will use the location data from your web browser to give you a list of nearby dentists
   - **No** – You'll need to enter the zip code to search within to get a list of nearby dentists

4. Click **Find Dentists** to see a list of nearby dentists meeting your search criteria

Automated Phone System

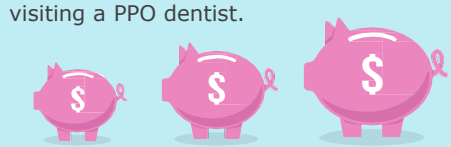
You can also find a dentist through our automated phone system by calling 800.352.6132 and following the prompts to find a dentist. Delta Dental dentists can be searched by zip code, specialty and plan type.

Understanding the Delta Dental Networks

Delta Dental PPO™ provides the lowest out-of-pocket costs. That's because PPO dentists agree to accept lower reimbursements for services.

Delta Dental Premier® provides a wider selection of dentists while keeping out-of-pocket costs economical.

You may visit any network dentist, but you will save the most money by visiting a PPO dentist.



Don't know which network your dental plan uses?

For dentist search purposes, your plan type is your network. You can usually find your plan name on your Delta Dental ID card or by signing in to the member portal. If you need help, feel free to contact Delta Dental of Arizona's customer service team at 800.352.6132.

DELTA DENTAL®

DeltaVision®

Gold Plan (Insight Network)
Summary of Benefits
For Group# 4693V-1000, 2000, 9901000
Phoenix Elementary School District

Benefits are subject to all provisions, terms and conditions of the Vision Certificate, including this Summary of Benefits and the Group Vision Contract.

Please note: The date of service is the date the procedure was performed unless otherwise noted below.

Control Plan – Delta Dental of Arizona

Benefit Year – January 1 through December 31

Child Age Limit – To age 26

Student Age Limit – To age 26

Covered Services –

Vision Care Services	In-Network	Out-of-Network
Exam with Dilation as Necessary	$10 Copay	$30
Retinal Imaging Benefit	Up to $39	Not Covered
Exam Options		
Standard Contact Lens Fit and Follow-Up	Up to $40	Not Covered
Premium Contact Lens Fit and Follow-Up	10% off Retail Price	Not Covered
Frames		
Any available frame at provider location	$0 Copay; $120 allowance, 20% off balance over $120	$60
Standard Plastic Lenses		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lenticular	$10 Copay	$55
Standard Progressive*	$75 Copay	$40
Premium Progressive*		
Tier 1	$95 Copay	$40
Tier 2	$105 Copay	$40
Tier 3	$120 Copay	$40
Tier 4	$75 Copay, 80% of charge less $120 Allowance	$40
Lens Options		
UV Treatment	$15 Copay	Not Covered
Tint (Solid and Gradient)	$15 Copay	Not Covered
Standard Plastic Scratch Coating	$15 Copay	Not Covered
Standard Polycarbonate - Adults	$40 Copay	Not Covered
Standard Polycarbonate - Kids under 19	$40 Copay	Not Covered
Standard Anti-Reflective Coating*	$45 Copay	Not Covered
Polarized	20% off Retail Price	Not Covered

Photocromatic/Transitions Plastic	$75	Not Covered
Premium Anti-Reflective*		
Tier 1	$57 Copay	Not Covered
Tier 2	$68 Copay	Not Covered
Tier 3	20% off Retail Price	Not Covered
Other Add-Ons	20% off Retail Price	Not Covered
Contact Lenses *(Contact lens allowance includes materials only)* Conventional	$0 Copay; $80 allowance, 15% off balance over $80	$64
Disposable	$0 Copay; $80 allowance, plus balance over $80	$64
Medically Necessary	$0 Copay, Paid-in-Full	$200
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	Not Covered
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network - Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids	Not Covered
Additional Pairs Benefit	Members also receive a 40% discount off complete pair prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used	Not Covered
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

*DDAZ reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

Additional Discounts – Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

Members also receive a 40% discount off complete pair prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service. Rates are valid for groups domiciled in the State of AZ.

Plan Exclusions –

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care; 9) Certain brand name Vision Materials in which the manufacturer imposes a no-

discount policy; 10) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 11) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Diabetic Services Rider –

Diabetic Care Services	Member Cost	Frequency	Out-of-Network Reimbursement
Office Service Visit *(Medical Follow-up Exam)* Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$77
Fundus Photography** Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$50
Extended Ophthalmoscopy** Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$15
Gonioscopy Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$15
Scanning Laser Type 1 and Type 2 diabetics	Covered 100% $0 copay	Up to 2 services per benefit year	$33

**Not covered if extended ophthalmoscopy is provided within 6 months.

Definitions –

Office Service Visit (Medical Follow-up Exam) is the office visit for the evaluation and management of an established patient. The office visit includes patient history, follow-up examination services as deemed appropriate by the provider, and medical decision making. Some or all of the diagnostic services described below will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above. More comprehensive descriptions of these services are available in the Certificate of Insurance.

- **Fundus Photography** with interpretation and report. Fundus photography is a process using optical imaging equipment to photograph structures of the eye.
- **Extended Ophthalmoscopy** with retinal drawing and interpretation and report. A serious retinal condition must exist or be suspected (based on results of routine ophthalmoscopy) which requires further detailed study.
- **Gonioscopy** procedure to look at the anterior chamber structures of the eye between the cornea and the iris. Gonioscopy can be used in detection or treatment of conditions that can be more prevalent in diabetics such as glaucoma or neovascularization of the angle.
- **Scanning.** Laser Scanning computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report.

Exclusions and Limitations – The Diabetic Benefit covers diabetic eye care evaluation services only. The following services and benefits are excluded:

1) Costs associated with securing frames, lenses, or any other materials.
2) Orthoptics or vision training and any associated supplemental testing.
3) Surgical procedures, including laser or any other form of refractive surgery, and any pre or post-operative services.
4) Pathological treatment of any type for any condition.
5) Any eye examination required by an employer as a condition of employment.
6) Insulin or any medications or supplies of any type.
7) Services and/or materials not included above.

Gold Plan (Insight Network)
Resumen de Beneficios
para el Grupo # 4693V-1000, 2000, 9901000
Phoenix Elementary School District

Los beneficios están sujetos a todas las provisiones, términos y condiciones del certificado de visión (en inglés, *Vision Certificate*), incluso este resumen de beneficios y el contrato de visión de grupo.

Nota: La fecha de servicio es la fecha en que se realizó el procedimiento a menos que se indique lo contrario a continuación.

Plan de Control: Delta Dental of Arizona

Año de beneficios: 1 de enero hasta el 31 de diciembre

Límite de edad para dependientes: hasta los 26 años

Servicios cubiertos:

SERVICIOS DE CUIDADO DE LA VISTA	BENEFICIO DENTRO DE LA RED	BENEFICIO FUERA DE LA RED
Examen ocular con dilatación según sea necesario	Copago $10	$30
Beneficio de escaneo retiniano	Hasta $39	No cubierto
Opciones de examen		
Ajuste y seguimiento de los lentes de contacto tipo estándar	Hasta $55	No cubierto
Ajuste y seguimiento de los lentes de contacto tipo premium	Descuento del 10% del precio de venta al público (PVP)	No cubierto
Monturas		
Cualquier montura disponible en la ubicación del proveedor	Copago $0; Beneficio de $120 Descuento del 20% al saldo que excede $120	$60
Cristales estándar de plástico		
Monofocal	Copago $10	$25
Bifocal	Copago $10	$40
Trifocal	Copago $10	$55
Lenticular	Copago $10	$55
Progresivos Estándar*	Copago $75	$40
Progresivos Premium *		
Nivel 1	Copago $95	$40
Nivel 2	Copago $105	$40
Nivel 3	Copago $120	$40
Nivel 4	Copago $75, 80% del cargo menos el beneficio de $120	$40
Opciones para cristales		
Protección UV	Copago $15	No cubierto
Tinte (sólidos y degradados)	Copago $15	No cubierto
Revestimiento anti-rayas, tipo estándar plástico	Copago $15	No cubierto
Policarbonato estándar - adultos	Copago $40	No cubierto
Policarbonato estándar - niños menores de 19 años	Copago $40	No cubierto
Revestimiento anti-reflejos, tipo estándar*	Copago $45	No cubierto

Revestimiento polarizado	Descuento del 20% del PVP	No cubierto
Fotocromáticas/Transición, de plástico	$75	No cubierto
Revestimiento anti-reflejos, tipo Premium*		
Nivel 1	Copago $57	No cubierto
Nivel 2	Copago $68	No cubierto
Nivel 3	Descuento del 20% del PVP	No cubierto
Otros complementos	Descuento del 20% del PVP	No cubierto
Lentes de contacto *(El beneficio para lentes de contacto incluye sólo materiales)*		
Convencionales	Copago $0; beneficio de $80 y descuento del 15% al saldo que excede $80	$64
Descartables	Copago $0; beneficio de $80, más el balance que excede $80	$64
Necesarias por razones médicas	Copago $0, pagado en su totalidad	$200
Corrección de visión por láser		
LASIK o PRK de U.S. Laser Network	Descuento del 15% del PVP o 5% del precio promocional	No cubierto
Amplifon Hearing Health Care	Servicios de salud auditiva de la red *Amplifon Hearing Health Care Network.* Los miembros reciben un descuento del 40% en exámenes de audición y una garantía de bajo precio en audífonos con descuento	No cubierto
Beneficio de pares adicionales	Los miembros también reciben un descuento del 40% en la compra de pares completas de lentes con receta y un descuento del 15% en lentes de contacto convencionales una vez que se ha aplicado el beneficio completo	No cubierto
Frecuencia		
Examen	Una vez cada 12 meses	
Lentes o lentes de contacto	Una vez cada 12 meses	
Montura	Una vez cada 12 meses	

*DDAZ se reserva el derecho de realizar cambios en los productos de cada nivel y en los gastos de bolsillo de los miembros. La fijación de los precios en cada nivel de producto depende de la marca comercial. No se les requiere a todos los proveedores de ofrecer todas las marcas en cada nivel de producto.

Descuentos adicionales: con los proveedores de la red, el miembro recibirá un descuento del 20% para artículos que no están cubiertos por el plan, el cual no se puede combinar con otros descuentos u ofertas promocionales. El descuento no se aplica a los servicios profesionales ni a los lentes de contacto del proveedor EyeMed. Los miembros también recibirán un descuento del 15% del PVP o un descuento del 5% en el precio promocional para Lasik o PRK de la red US Laser Network, propiedad y operada por LCA Vision.

Los miembros también reciben un descuento del 40% en las compras de pares completas de lentes con receta médica y un descuento del 15% en los lentes de contacto convencionales una vez que se haya aplicado el beneficio completo. Después de la compra inicial, los lentes de contacto de reemplazo se pueden obtener vía el Internet en ahorros substanciales y se envían directamente al miembro. Los detalles están disponibles en www.eyemedvisioncare.com. El beneficio para los lentes de contacto no es aplicable a este servicio. Las tarifas son válidas para grupos domiciliados en el estado de Arizona.

Exclusiones del plan:

1) Entrenamiento de la visión ortóptica, ayudas para la visión subnormal y cualquier examen suplementaria asociada; lentes aniseicónicas; 2) Tratamiento médico y/o quirúrgico del ojo, ojos o estructuras de apoyo; 3) Cualquier examen ocular o de la visión, o cualquier tipo de anteojos correctivos requerido por un titular de seguro como una condición de

empleo; protección ocular; 4) Servicios proporcionados como resultado de cualquier ley de indemnización para trabajadores (en inglés, *Worker's Compensation*), o legislación similar, o requeridos por cualquier agencia gubernamental o programa federal, estatal o subdivisiones de los mismos; 5) Lentes y/o lentes de contacto tipo *Plano* (sin receta); 6) Gafas de sol sin receta médica; 7) Dos pares de lentes en lugar de bifocales; 8) Servicios o materiales proporcionados por cualquier otro plan de beneficios de grupo que proporcione atención de la vista; 9) ciertos materiales de la visión de marca comercial en los que el fabricante impone una política de no permitir descuento; 10) Servicios prestados después de la fecha en que una persona asegurada pierde la cobertura bajo la póliza, salvo cuando los materiales de visión hayan sido ordenados antes de la fecha en que termine la cobertura y los servicios prestados a la persona asegurada estén dentro de los 31 días de la fecha de dicha orden. 11) No se reemplazarán cristales, monturas, lentes, o lentes de contacto perdidos o rotos excepto en la próxima frecuencia de beneficios cuando los materiales de visión estén disponibles.

Anexo de Servicios para Diabéticos:

SERVICIOS DE ATENCIÓN A LA DIABETES	COSTO PARA EL MIEMBRO	FRECUENCIA	REEMBOLSO FUERA DE LA RED
Visita de servicio en el consultorio *(Consulta de seguimiento médico)* Diabéticos tipo 1 y tipo 2	Cubierto 100% Copago $0	Hasta 2 servicios por año de beneficios	$77
Fotografía del fondo del ojo** Diabéticos tipo 1 y tipo 2	Cubierto 100% Copago $0	Hasta 2 servicios por año de beneficios	$50
Oftalmoscopia extendida** Diabéticos tipo 1 y tipo 2	Cubierto 100% Copago $0	Hasta 2 servicios por año de beneficios	$15
Gonioscopía Diabéticos tipo 1 y tipo 2	Cubierto 100% Copago $0	Hasta 2 servicios por año de beneficios	$15
Escaneo con láser Diabéticos tipo 1 y tipo 2	Cubierto 100% Copago $0	Hasta 2 servicios por año de beneficios	$33

**No está cubierto si se lleva a cabo la oftalmoscopia extendida dentro de 6 meses.

Definiciones:
Consulta de servicio en el consultorio (examen de seguimiento médico) es la visita al consultorio para la evaluación y gestión de tratamiento de un paciente establecido. La visita al consultorio incluye la historia clínica del paciente, servicios de examen de seguimiento según lo considere adecuado el proveedor y la toma de decisiones médicas. Algunos o todos los servicios de diagnóstico descritos a continuación se proporcionarán según se considere adecuado, sujeto a la determinación del proveedor de la necesidad de servicio y las limitaciones de frecuencia de beneficios anteriormente mencionadas. Descripciones más completas de estos servicios están disponibles en el Certificado de Seguro.

- **Fotografía del fondo** del ojo con interpretación e informe. La fotografía del fondo del ojo es un proceso que utiliza equipos ópticos de imágenes para fotografiar estructuras del ojo.
- **Oftalmoscopia extendida** con dibujo e interpretación retiniano. Una condición retiniana seria debe existir o ser sospechada (basado en resultados de la oftalmoscopia rutinaria) que requiere estudio detallado adicional.
- **Procedimiento de gonioscopía** para observar las estructuras de la cámara anterior del ojo, entre la córnea y el iris. La gonioscopía se puede utilizar en la detección o el tratamiento de enfermedades que pueden ser más frecuentes en diabéticos como el glaucoma o la neovascularización del ángulo.
- **Escaneo. Escaneo con láser** computarizado de imágenes de diagnóstico oftálmico, segmento posterior con interpretación e informe.

Exclusiones y limitaciones: el beneficio para diabéticos se limita a los servicios de evaluación del cuidado de la vista para diabéticos. Se excluyen los siguientes servicios y beneficios:

1) Costes asociados con procurar monturas, lentes o cualquier otro material.
2) Entrenamiento ortóptica o de la visión y cualquier examen complementaria asociada.
3) Procedimientos quirúrgicos, incluso láser o cualquier otra forma de cirugía refractiva, y cualquier servicio pre o posoperatorio.

4) Tratamiento patológico de cualquier tipo para cualquier condición.
5) Cualquier examen de los ojos requerido por un empleador como condición de empleo.
6) Insulina o cualquier medicamento o insumo de cualquier tipo.
7) Servicios y/o materiales no incluidos anteriormente.

DELTA DENTAL

DeltaVision® administered by EyeMed

Vision benefits never looked so good

With DeltaVision administered by EyeMed, you:

- Have access to one of the nation's largest networks of independent eye doctors and national retail and regional retail providers.
- Receive care when it's convenient for you

  –with extended weeknight and weekend hours and online appointment scheduling.
- Can use Glasses.com and ContactsDirect.com as in-network providers to easily find and purchase glasses and contacts–all shipped directly to your front door.
- Have tools and resources that make using your benefit an experience you'll appreciate:
  - – Enhanced provider searches to find the right provider
  - – Optimized web and mobile resources
  - – Award-winning, customer care available day and night

Plus...

40% off additional pairs of glasses or prescription sunglasses[1]

20% off any remaining balance over the frame allowance[2]

20% off non-prescription sunglasses[2]

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

[1] Available at in-network provider locations
[2] Not insured benefits. Discounts on non-covered services may not be available through all providers or in all stores

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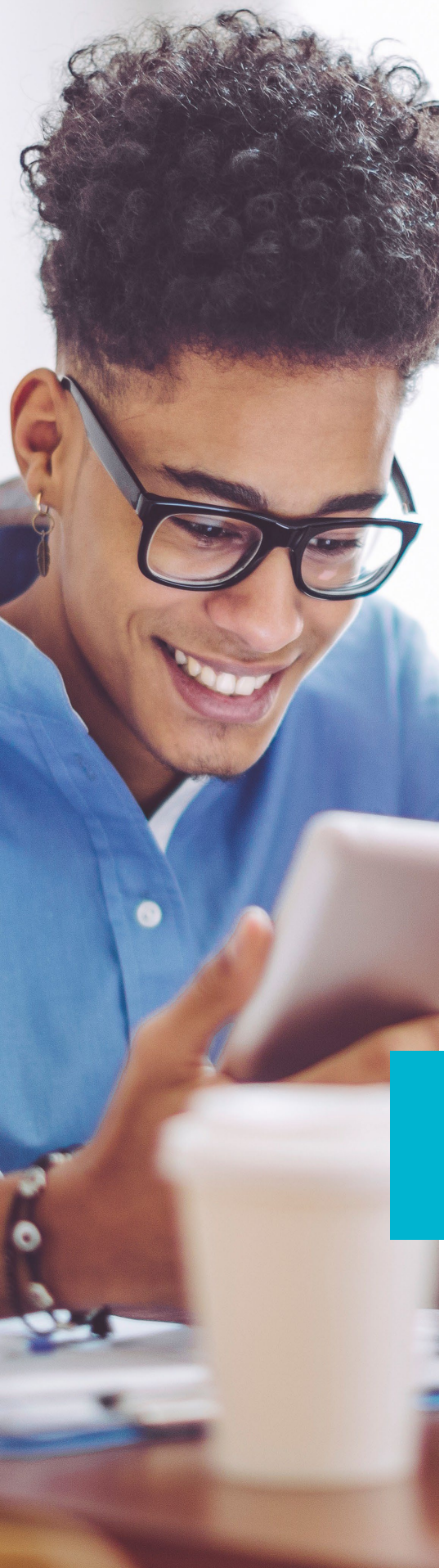

DELTA DENTAL

DeltaVision® administered by EyeMed

Need to know how to use your vision benefit?

Welcome to DeltaVision! We've made it easier than ever to access your vision benefit information and schedule your annual eye exam. Everything you need is available through our member vision portal.

Here's How It Works

Follow these simple steps to access and use your DeltaVision benefits:

1. Register and log in to the member vision portal at EyeMedVisionCare.com
2. Review your vision benefit information.[1]
3. Find a provider near you and schedule an appointment.
   Note: If the provider says they do not accept DeltaVision administered by EyeMed, ask if they accept EyeMed. Your plan uses the EyeMed Insight network.

Finding a Provider

Log in to the vision portal and select "Locate a Provider." You may need to select your network (Insight). Enter your zip code to be connected with eye health experts near you.

Questions?

Feel free to contact our award-winning Customer Care Center[2] at 866.605.4242.

Did You Know...

You can receive services even if you don't have your ID card. Just provide your name and birthdate so the office can verify your vision benefits.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL

[1]Actual benefits and frequencies vary by plan.
[2]Purdue University BenchmarkPortal independent assessment of call centers nationwide.

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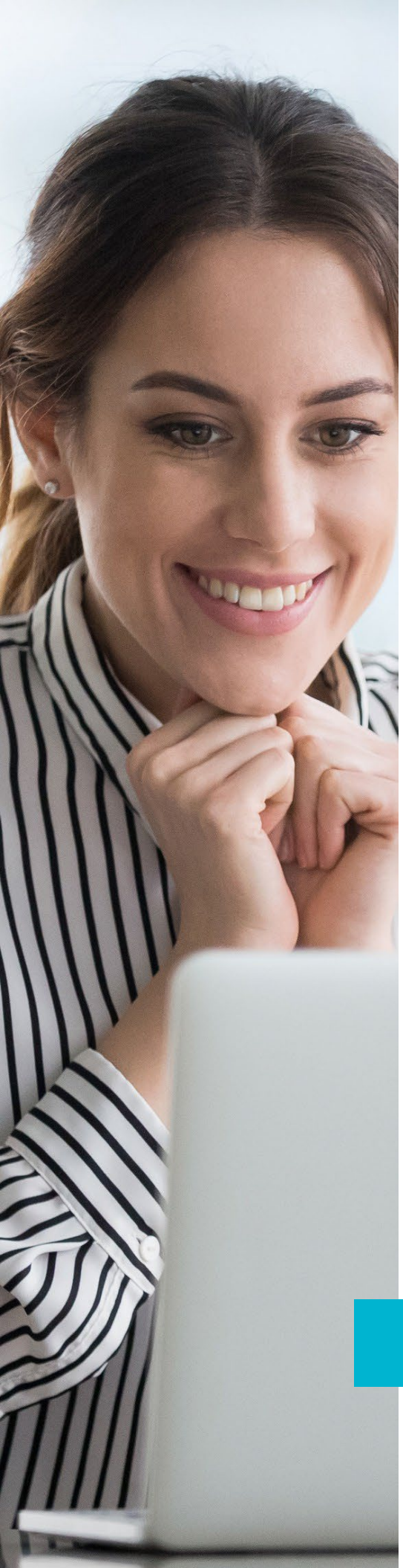


DELTA DENTAL

DeltaVision® administered by EyeMed

Easily access your vision plan information

Your vision plan information should be easy to see. And, since DeltaVision® is administered by EyeMed, that's exactly what it is—easy. The EyeMed member portal at eyemed.com is your vision plan control center. A place to manage the details of every visit to the eye doctor and every vision claim submitted. Online. Anytime. Anywhere.

Start Managing Your Vision Plan in a Few Easy Steps:

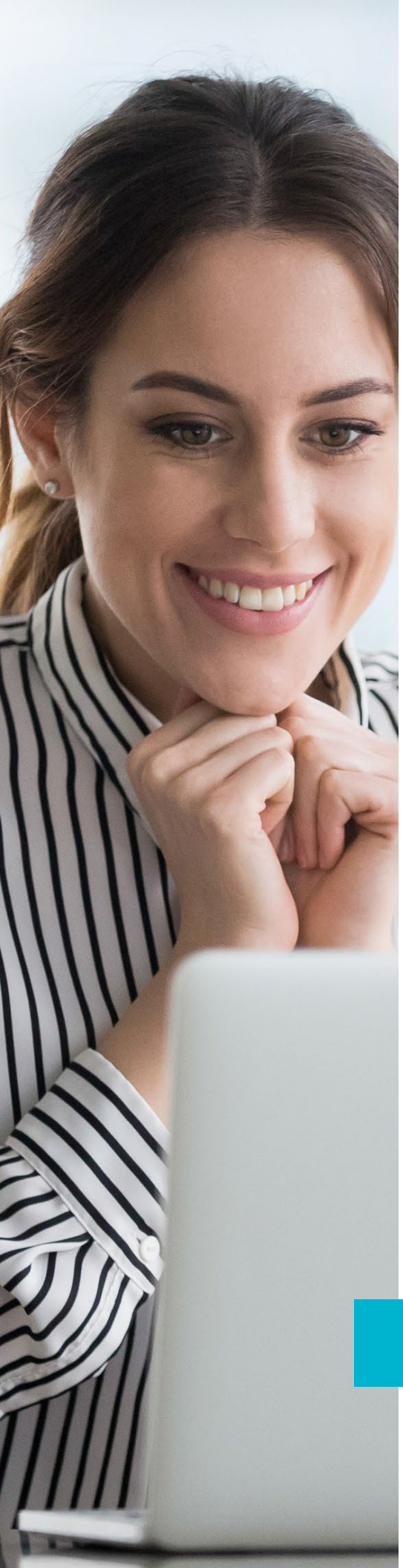
1. Visit eyemed.com and click **Member Login.**
2. If you're a new user, click **Create an Account.**
3. Register using your member ID or the last four digits of your social security number. (You'll get an email asking you to confirm your account)1
4. Finish setting up your new account with your email address and a password.

Log in 24/7 to:

- View your benefit details
- Confirm eligibility
- Check claim status
- Print replacement ID cards
- Locate a provider
- Schedule an appointment online2
- View health and wellness information

Register for the EyeMed member portal at eyemed.com today!

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL



DELTA DENTAL

DeltaVision®
administrado por EyeMed

Puede acceder fácilmente a su plan de visión

Debe ser fácil de ver la información sobre su plan de visión. Y, como DeltaVision® está administrado por EyeMed, es precisamente así – fácil. El portal de los miembros Eyemed, localizado en eyemed.com, es el centro de control para la gestión de su plan de visión. Un lugar para disponer de los detalles de cada visita al oculista y cada reclamo de visión presentado. En línea. En cualquier momento. En cualquier lugar.

Comience a administrar su plan de visión en unos sencillos pasos:

1. Visite eyemed.com y haga clic en el botón de acceso, *Member Login*.
2. Si es un nuevo usuario, haga clic en ***Create an Account*** para crear una cuenta.
3. Inscríbase utilizando su ID de miembro, o los últimos cuatro dígitos de su número de seguro social. (Recibirá un correo electrónico pidiéndole que confirme su cuenta)1
4. Termine de configurar su nueva cuenta con su dirección de correo electrónico y una contraseña.

Inicie sesión 24/7 para:

- Ver los detalles de sus beneficios
- Confirmar la elegibilidad
- Verificar el estado de un reclamo
- Imprimir tarjetas de ID de repuesto
- Encontrar un proveedor
- Programar una cita en línea2
- Leer información sobre la salud y bienestar

Inscríbase hoy en eyemed.com para usar el portal de miembros EyeMed

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

continúa en la página 2

DELTA DENTAL

DeltaVision® administered by EyeMed

EyeMed mobile app

Your DeltaVision® plan is administered by EyeMed, which means you have access to tools and resources that make accessing and using your vision benefit easy—no matter where you are.

Get the Latest EyeMed Members App:

1. **Download.** Search "EyeMed Members" in the App Store (iOS) or Google Play (Android).
2. **Open.** You can use some features right away; others unlock once you register.
3. **Register.** you'll need your member ID or the last four digits of your social security number.
4. **Log In.** If you've already registered on eyemed.com, you can log onto the app the same way.

Ready When You Download:

1. Find nearby network providers
2. On-the-fly appointment scheduling
3. Turn-by-turn directions and map
4. Direct line to EyeMed support

Unlocked When You Register:

1. Eye exam and contact lens reminders
2. Electronic ID card for office visits
3. Save vision prescriptions3
4. Benefit plan details

Download the EyeMed Member App from the App Store (iOS) or Google Play (Android) today!

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL

[1]Depends on how your vision benefit administrator entered you into the system.
[2]Most, but not all, network providers offer the ability to schedule appointments online.
[3]Take a picture of your prescription and store it in the app. No need to type in the numbers.

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DELTA DENTAL

DeltaVision®
administrado por EyeMed

App móvil de EyeMed

Su plan de DeltaVision® está administrado por EyeMed, lo cual significa que Ud. tiene acceso a herramientas y recursos para que pueda acceder y usar fácilmente los beneficios de su plan – no importa dónde esté usted.

Instale la más última app para miembros de EyeMed:

1. **Para Descargar,** busque "EyeMed Members" en el App Store (iOS) o Google Play (Android).
2. **Para Abrir,** puede utilizar algunas funciones de inmediato; otros se desbloquean una vez que se inscriba.
3. **Para Inscribirse,** necesitará su ID de miembro o los últimos cuatro dígitos de su número de seguro social.
4. **Para Iniciar sesión,** si ya se ha inscrito en eyemed.com, puede iniciar sesión en la aplicación de la misma manera.

Al descargar la aplicación tendrá disponible:

1. Buscador para los proveedores locales dentro de la red
2. Programación de citas sobre la marcha
3. Mapa con direcciones detalladas de ruta
4. Línea directa a los servicios de apoyo EyeMed

Al inscribirse podrá recibir:

1. Recordatorios para exámenes de ojos y lentes de contacto
2. Tarjeta de identificación electrónica para visitas de oficina
3. Sitio seguro para guardar su receta de visión3
4. Los detalles de su plan particular de beneficios

Puede descargar la aplicación móvil para miembros de EyeMed desde la App Store (iOS) o Google Play (Android) ¡Hágalo hoy!

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL

[1]EyeMed1Depende de cómo su administrador de servicios de visión haya introducido los datos de usted al sistema.
[2]La mayoría, pero no todos los proveedores de la red ofrecen la posibilidad de programar citas en línea.
[3]Tome una foto de su receta médica y guárdela en la app. No hay necesidad de escribir los números.

PDF-1609-R-538

WHAT IS AN FSA?

A Flexible Spending Account (FSA) is a pre-tax program your employer sponsors that allows you to save Federal, state and Social Security (FICA) taxes on eligible expenses. When you enroll in a FSA, you increase your take-home pay and improve your bottom line!

How It Works

Under this plan you can use pre-tax money to pay for up to four different kinds of expenses, including: your medical, dental and vision care expenses that are not covered by your insurance;
the cost of caring for a dependent while you work; the cost of dental, vision and accident insurance not provided by your employer; and, your cost for adopting a child.

When You Enroll

When you enroll you determine the amount of expenses you anticipate for the upcoming year. The benefits you elect are paid for with pre-tax dollars deducted from your paycheck each payroll period. These dollars are subtracted from your gross earnings before taxes are taken out.

Your Benefits Are Enhanced

FSAs are designed to cut predictable costs while increasing your take-home pay. Maximize every dollar by taking advantage of this benefit choice. Alleviate those high out-of-pocket expenses by enrolling in a plan that works for you.

Your Spendable Income Increases

When you elect pre-tax benefits under a flexible benefits plan, you lower your taxable income on your W-2; therefore, you pay less in taxes and increase your spendable income. Depending on your tax bracket, this plan can save you 30% to 40% on qualifying expenses

Whose Expenses are Eligible?

Under the plan, only the expenses of a participant, a participant's spouse or a participant's dependent(s) qualify for pre-tax treatment. If you are unsure if a person qualifies as an eligible dependent, please refer to P&A's website for a more detailed definition.

SAMPLE ELIGIBLE EXPENSES FOR FSA REIMBURSEMENTS

CARES Act of 2020 Update

Over-the-counter (OTC) medications are now reimbursable under FSAs without requiring a prescription or completing a Letter of Medical Necessity Form. This provision is retroactive to January 1, 2020. Menstrual care products are now reimbursable as eligible expenses, including tampons and pads.

Eligible Health FSA Expenses

- Acupuncture
- Alcoholism treatment
- Allergy medication, nasal sprays
- Ambulance
- Analgesics, fever reducers, pain reducers (aspirin, ibuprofen, acetaminophen)
- Antacids and heartburn relief
- Antibiotic ointments
- Anti-itch creams and hydrocortisone creams
- Arthritis pain relieving creams
- Athlete's foot treatment, anti-fungal creams
- Artificial teeth/dentures
- Bandages
- Birth control
- Blood pressure monitors
- Braces
- Braille-books and magazines
- Breast pumps and lactation supplies
- Cancer screening
- Chiropractors
- Chondroitin
- Co-insurance amount you pay
- Cold/hot packs
- Cold medicines, tablets, syrups, cough drops & lozenges
- Co-pay amount you pay
- Compression hose (30-40 mmHg or higher)
- Condoms
- Contact lenses and eyeglasses
- Contact lens solutions
- Cost of medically necessary operations and related treatments
- Crutches
- Deductible medical coverage (amounts you pay)
- Dental fees
- Diabetic supplies
- Diaper rash ointment
- Drug addiction treatment
- Doula
- Ear wax removal kits
- Eye exams, eye surgery
- Eye glasses (protection plans/ warranties are NOT eligible expenses)
- Eczema treatments
- Feminine hygiene products
- Fertility treatments (in vitro fertilization, surgery)
- First-aid cream
- Glucosamine
- Hearing devices and batteries
- Hemorrhoid treatments
- Hospital services
- Incontinence products
- Infertility treatments
- Insulin
- Laboratory fees
- Lactose intolerance tablets
- Lamaze classes
- Latex gloves
- Laxatives
- Medical alert bracelets
- Medical information plan
- Menstrual pain relievers
- Mentally handicapped persons cost of special home care
- Motion sickness pills
- Nasal spray and strips
- Nicotine gum, patches
- Nursing fees (including boarding)
- Obstetrical expenses
- Orthotics
- Over-the-counter medications
- Oxygen
- Petroleum jelly
- Prosthesis
- Pregnancy tests
- Prenatal vitamins
- Psychiatrists' and psychologists' fees
- Radial keratotomy and lasik eye surgery
- Routine physical & other non diagnostic services or treatments
- Sinus medication
- Smoking cessation programs
- Speech therapy
- Special education for the blind
- Special plumbing for handicapped
- Sterilization (i.e., tubal ligation,vasectomy) and reversal
- Stomach and digestive relief items
- Sunburn cream (Solarcaine)
- Surgical fees
- Telephone, special for hearing impaired
- Television audio display equipment for hearing impaired
- Therapeutic care for drug and alcohol addiction received as medical treatment
- Thermometers
- Toothache and teething pain relievers
- Transportation expenses for person to receive medical care
- Urinary pain relief medication
- Vaccines
- Walkers
- Wart removal, i.e., W Freeze Off (certain wart medicines may require a prescription)
- Wheelchair
- X-rays
- Yeast infection medication

Eligible Health FSA Expenses Only with a Letter of Medical Necessity Form

- Compression hose (20-30 mmHg)
- Dietary supplements
- Exercise programs or equipment
- Fiber supplements
- Humidifier
- Hypnosis
- Lead-base paint removal
- Massage therapy, rolfing therapy
- Mineral supplements
- Occupational therapy
- Orthopedic shoes *(Reimbursement is permitted for the cost difference between orthopedic shoes and regular shoes.)*
- Scooter, electric
- Service animal (guide dogs are eligible without a LOMN)
- Tuition/meals/lodging for special needs schooling
- Varicose vein, treatment of
- Vitamins
- Water-Pik

SAMPLE ELIGIBLE EXPENSES FOR FSA REIMBURSEMENTS

Never Eligible

- COBRA premiums
- Concierge service fees - *only medical services actually provided are eligible for reimbursement; membership fees for concierge services are not eligible for reimbursement*
- Cosmetic products and cosmetic surgery (unless to remediate damage from an illness or injury)
- Disposable diapers
- Diet program foods
- Electric toothbrush
- Electrolysis
- Fitness programs*
- Hair transplants*
- Household help
- Maternity clothes
- Teeth whitening*

**Unless prescribed by a doctor to treat an existing illness or injury.*

Eligible Dependent Care FSA Expenses

- Babysitters
- Daycare centers
- Nursery schools
- After-school programs
- Day camp
- Eldercare
- (Overnight camps are NOT eligible)

Expense eligibility is subject to change. If you are unsure if an expense is eligible for reimbursement, please call P&A Group at (800) 688-2611 or chat with customer service through online webchat at **www.padmin.com**. For a more extensive eligible expense list, you can also visit **www.padmin.com**.

What Is a Dependent Care Assistance Flexible Spending Account?

A Dependent Care Assistance Flexible Spending Account (FSA) allows you to set aside a portion of your pay pre-tax to use for child day care or elder care expenses. Because it is deducted from your pay before taxes, you can save up to 30% on each dollar you spend on eligible expenses (depending on your tax bracket).
If you are a New Jersey or Pennsylvania taxpayer, the New Jersey or Pennsylvania state income tax will apply to money withheld from your pay for any benefits you elect.

Under tax laws, dependent day care expenses are eligible only if the expenses are necessary so that you and your spouse can work or attend school full-time. Your spouse also may be unemployed but actively looking for work. If your spouse works part-time, your election may not exceed the lesser of your annual income or your spouse's annual income.

PLEASE NOTE: Non-custodial parents check with your legal or tax advisor to see if special rules apply to you that would enable you to utilize this account.

Eligible Day Care Expenses May Be Reimbursed For...

• Your "qualifying child" (including a stepchild, foster child, child placed for adoption or younger brother/ sister) under age 13 who has the same principal residence as you for more than one half the year and does not provide more than one-half of his or her own support during the calendar year

• Your spouse or other dependent who receives over one-half of his/her support from you (i.e., your disabled elderly parent) and has the same principal place of residence as you for more than one-half of the year

Determining Your Election Amount

During your benefits Open Enrollment, you need to estimate how much you usually spend on eligible daycare expenses in a year and set aside that dollar amount into your FSA (this is also called your annual election). *Per IRS regulations, if you have unspent money left over in your account at the end of the plan year the money will be forfeited- it does not apply to the next plan year.* Your annual election is divided by the number of paychecks you have in a year and deducted pre-tax from your paycheck each pay period. The maximum annual election amount is $5,000. This is a "pay-as- you-go account" which means that you can only have access to the amount of money that has been payroll deducted to date.

Example

If you set aside $2,500 into this account and get paid weekly, the amount of money that will be deducted pre-tax from your paycheck each week is $48.07.

$2,500 annual election amount ÷ by 52 paychecks= $48.07 deducted pre-tax from each paycheck

Changing Your Election Amount

Generally, you can change your election amount if you experience the following: 1) change in status (i.e., marriage or divorce), 2) a reduction or increase in the hours that you and/or your spouse work, and 3) a change in the place where you, your spouse or your dependent work or reside.

Eligible Dependent Care Assistance FSA Expenses

- Payments to nursery schools, day care centers or individuals who satisfy all state and local laws and regulations
- Payments for before-school care and after-school care beginning with kindergarten and higher grades
- Payments to relatives for care of a qualifying dependent(s); however, the relative cannot be your tax dependent or your child if under age 19 as of the end of the calendar year
- Payments (in lieu of regular day care) to day camp (e.g., soccer camp, computer camp, etc.) but not overnight camps
- Payments to adult daycare centers
- Payments to senior daycare
- Payment for eldercare so that you can work or look for work

Ineligible Dependent Care Assistance FSA Expenses

- Tuition expenses for education of a qualified dependent beginning with kindergarten and higher grades
- Expenses incurred while you and/or your spouse are not working (except for short temporary absences like vacation and minor illnesses)
- Expenses for overnight camps
- Nursing home care
- Custodial elder care that is NOT in place so that you can work
- Transportation fees
- Prepayment for services not received while covered
- Late payment fees

Filing a Claim

To receive reimbursement from your account simply save a copy of the proof of the expense (i.e., a receipt from the daycare provider) and submit it to P&A Group. Claim reimbursement is based on the date you receive the dependent day care service, not the date you pay the invoice or the date you are billed.
Remember, you will only be reimbursed up to your available balance in your Dependent Care Assistance FSA on the processing date.

Claim Submission Options*

QuikClaim

Instantly submit claims and receipts directly through your smartphone. Capture a picture of your receipt or other supporting documentation of your eligible expense. Log into your P&A Account from your mobile device and select **Submit a Claim.**

Electronic Claim Upload

Enter claims directly online from your computer or laptop. Log into your account at www.padmin.com, select **Upload Claim/Documentation** under the Member Tools tab and follow the instructions.

Fax/Mail a Claim Form

Claim forms are available by logging into your account at www.padmin.com. Complete a form and submit it via fax or mail to P&A Group.

Fax: (877) 855-7105

Mailing Address: P&A Group 17 Court Street, Suite 500 Buffalo, NY 14202

**When submitting a claim, make sure to include a proof of service documentation (register receipts, etc).*

Customer Service

HOURS: Monday - Friday 8:30AM - 10:00PM ET.

PHONE: (800) 688-2611 | WEB: www.padmin.com

- Online chat available during customer service hours
- Toll-free account information available in English and Spanish
- Visit P&A Group's mobile site @ www.padmin.com on your smartphone

CONTACT US

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

SUMMARY OF GROUP LIFE INSURANCE

For the Employees of

Phoenix Elementary School District #1

For coverage effective July 1, 2024.The information in this summary may be replaced by any subsequently issued summary or policy amendment.

GROUP BASIC LIFE INSURANCE & ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Description of Life Insurance Basic Life Insurance is term life coverage made available through your employer. Term life insurance is the most common type of life insurance and, initially, usually is the least expensive. To put it simply, it pays a death benefit if you die while you have coverage.

Description of AD&D Insurance This benefit pays an additional benefit in the event of loss of life or contractually defined injury. Coverage can be extended for other reasons not qualified as — but relating to — accidental death or dismemberment. Refer to your employee certificate for details.

Eligibility All Other Active Employees working a minimum of 30 hours each week.

Benefits All Other Active Employees- 1 x your Basic Annual Earnings rounded to the next higher $1,000 not to exceed $100,000 of Basic Life and AD&D coverage at no cost to you paid for by your employer.

Additional AD&D Benefits Loss of Life, Loss of Speech and/or Hearing, Loss of Hand, Foot or Eye, Loss of Thumb and Index Finger on one Hand, Paralysis Benefit, Seat Belt/Airbag Benefit and Repatriation Benefit are included under AD&D for actively insured employees. Child Education, Day Care, Rehabilitation, Spouse Education and Adaptive Home and Vehicle benefits are included under AD&D at or the actual cost. Certain restrictions apply. Refer to your employee certificate.

Waiver of Premium With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for an employee that becomes disabled. Certain restrictions apply. Refer to your employee certificate.

Accelerated Death Benefit If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Refer to your employee certificate.

Conversion A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions are met. Refer to your employee certificate.

Benefit Reduction

Benefit amounts will be reduced by the following percentages according to age category:

- 35% at Employee's age 70
- 55% at Employee's age 75
- 70% at Employee's age 80

Benefit reduction will apply to the original benefit amount in force and will be rounded to the nearest $1000.

GROUP SUPPLEMENTAL LIFE INSURANCE & SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Eligibility

All Other Active Employees working a minimum of 30 hours each week.

Benefits

- All Active Administrative Employees – Increments of $10,000 to a maximum of $500,000, not to exceed 5 x Basic Annual Earnings of Supplemental Life coverage and Supplemental AD&D coverage.
- Spouse – Increments of $5,000 to a maximum of $150,000 not to exceed 50% of Employee's Supplemental Life coverage amount
- Child (ren) – for child (ren) ages 15 days to 26 years old, Increments of $1,000 to a maximum of $10,000 of Supplemental Life coverage.

Evidence of Insurability

Evidence of Insurability is required for all amounts of insurance selected after the initial 31 day eligibility period. Evidence of Insurability is required for Employee Supplemental Life Insurance amounts in excess of $250,000

Evidence of Insurability is required for Spouse Supplemental Life Insurance amounts in excess of $50,000.

Conversion

A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions are met. Refer to your employee certificate.

Portability

This coverage may be continued at group rates upon termination of employment. Certain restrictions apply. Refer to your employee certificate.

Waiver of Premium

With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for an employee that becomes disabled. Certain restrictions apply. Refer to your employee certificate.

Accelerated Death Benefit

If an employee has been diagnosed as Terminally Ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Refer to your employee certificate.

Benefit Reduction

Employee:

Benefit amounts will be reduced by the following percentages according to age category:

- 35% at Employee's age 70
- 55% at Employee's age 75
- 70% at Employee's age 80
- 80% at Employee's age 85
- 85% at Employee's age 90

Benefit reduction will apply to the original benefit amount in force and will be rounded to the nearest $1000.

Spouse:

Benefit amounts will be reduced by the following percentages according to age category:

- 35% at Employee's age 70
- 55% at Employee's age 75
- 70% at Employee's age 80
- 80% at Employee's age 85
- 85% at Employee's age 90
- Benefit reduction will apply to the original benefit amount in force and will be rounded to the nearest $1000.

PHOENIX #1
Elementary School District

SYMETRA SUPPLEMENTAL LIFE AND AD&D COVERAGE

Eligible employees have the option to elect Supplemental Life coverage for themselves, their spouse, and dependent child(ren). Employees may also elect Supplemental Accidental Death & Dismemberment (AD&D) coverage for themselves.

To be eligible, you must be an active employee working a minimum of 30 hours each week.

All Active Administrative Employees may elect coverage in increments of $10,000 to a maximum of $500,000, not to exceed 5 x Basic Annual Earnings of Supplemental Life coverage and Supplemental AD&D coverage. Spouse Life coverage may be elected in increments of $5,000 to a maximum of $150,000 not to exceed 50% of Employee's Supplemental Life coverage amount. Life coverage for a child ages 15 days to 26 years old is available in increments of $1,000 to a maximum of $10,000 of Supplemental Life coverage.

Please refer to the Benefits Guide for additional information on plan coverage, limitations, and conditions for coverage.

RATES FOR SUPPLEMENTAL LIFE AND AD&D

Employee Supplemental Life Rates per $1,000 of coverage.

Employee's Age	Rates	Employee's Age	Rates
Under 25	$0.040	50-54	$0.237
25-29	$0.040	55-59	$0.371
30-34	$0.045	60-64	$0.579
35-39	$0.054	65-69	$1.039
40-44	$0.084	70-74	$1.859
45-49	$0.143	75 and over	$3.066

Spouse Supplemental Life Rates per $1,000 of coverage.

Spouse's Age	Rates	Spouse's Age	Rates
Under 25	$0.053	50-54	$0.315
25-29	$0.053	55-59	$0.493
30-34	$0.059	60-64	$0.769
35-39	$0.072	65-69	$1.380
40-44	$0.112		
45-49	$0.191		

Child Supplemental Life rate per $1,000 of coverage: $0.100

Employee AD&D rate per $1,000 of coverage: $0.015

Your rate will change when you have a birthday that moves you up into a higher age band. The new rate will take effect on July 1st after the age change. For example, you are currently age 49 and you turn 50 on October 5, 2023. On July 1, 2024, your rate will change from $0.143 to $0.237. This same rule applies to a spouse's age change.

HOW TO CALCULATE YOUR COST

Employee Life: (Coverage Amt.) / (volume) x (See age rates) / (rate) /1,000= $_____ Monthly Cost

Employee AD&D: (Coverage Amt.) / (volume) x $0.015 / (rate) /1,000= $_____ Monthly Cost

Spouse Life: (Coverage Amt.) / (volume) x (See age rates) / (rate) /1,000= $_____ Monthly Cost

Child Life: (Coverage Amt.) / (volume) x $0.100 / (rate) /1,000= $_____ Monthly Cost

$_____
Total Monthly Cost

This information provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please call 1-800-426-7784 or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-017015-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information contained herein and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits. **For Class 3 Employees Only.**

SYMETRA
RETIREMENT | BENEFITS | LIFE

Group Disability Insurance

Core Short Term Disability with Buy-Up Option

SUMMARY OF BENEFITS

Class 1

Sponsored By: **Phoenix Elementary School District #1**

Policy Number: **01-017015-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Benefit Highlights: EMPLOYER PAID CORE PLAN

Benefit Amount	66.67% of weekly salary up to $2,000 per week
Minimum Benefit Amount	$10
Maximum Benefit Duration	17 weeks
Elimination Period	Accident – 60 days Sickness – 60 days (number of days you must be disabled to collect disability benefits)
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Benefit Highlights: EMPLOYEE PAID BUY-UP PLAN

Benefit Amount	66.67% of weekly salary up to $2,000 per week
Minimum Benefit Amount	$10
Maximum Benefit Duration	24 weeks
Elimination Period	Accident – 14 days Sickness – 14 days (number of days you must be disabled to collect disability benefits)
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Eligibility

All active full-time employees working a minimum of 30 hours per week.

Standard Provisions:

- Maternity is covered the same as any other condition.
- Non-Occupational Coverage.
- Recurrent disability/temporary recovery.

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-017015-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

JORGENSEN brooks group
Employee Assistance Programs

PHOENIX #1
Elementary School District

You. Your family. Your job.

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

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

What types of problems are covered by JBG Clinical Care?

Confidential assessment and brief counseling for:

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

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

Call **Jorgensen Brooks Group** at **520-575-8623** [toll free, **888-520-5400**].
Local, in-person clinical appointments can be made Monday through Friday, 8:00am through 4:30pm. Virtual / Video, telephone and Internet Chat clinical appointments with licensed therapists are also offered. ***Crisis services are available 24 hours/7 days.***

How many counseling sessions are available?

You and your family members can have up-to-**six [6]** free sessions per problem, per person, per year. Counseling for a specific problem [regardless of the number of sessions provided] requires a one-year break before sessions can again be provided for that problem. Sessions for marital / relationship and family / child situations are authorized for the group involved; separate sessions may be authorized for individuals upon clinical review. Adult children living in the household may receive services until the age of 26.

What if I need services beyond JBG Clinical Care?

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

JBG Clinical Care

Your employer is not told who uses ***JBG Clinical Care*** or ***JBG Personal Care***.

Call – 24 hours/7 days
Tucson: 520-575-8623
Toll Free: 888-520-5400

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

Call - 24 hours / 7 days
Tucson: 520-575-8623
Toll Free: 888-520-5400

JBG Personal Care Website

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

Live Chat

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

Mobile App - *EAP / Assist*

⇒ Download from Google Play [android] or App Store [IOS]
⇒ Register on the app
⇒ Enter Employer number [Employer / Company Name] and standard password "JBG" [not case sensitive]

JBG Personal Care

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

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

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

JORGENSEN brooks group
Employee Assistance Programs

Introducing the *EAP / Assist* Mobile App

NOW AVAILABLE ON

ANDROID APP ON Google play

Download on the App Store

24 / 7 / 365

JBG's success is live response from professionals, 24 hours / 365 days, creating an "always open" mental health service.

ACCESS

The mobile app gives you access to over 5,000 articles, resources and links to through a searchable database.

UNLOCK

You can unlock all the features JBG Personal care has to offer with 100's of resources at the tip of your fingers.

EAP / ASSIST APP GIVES YOU INSTANT ACCESS TO RESOURCES FOR

- Parenting
- Adoption
- Child Care
- Kid's Wellbeing
- Education
- Aging Well Home Care Personal
- Health Caregivers
- Grief and Loss
- Personal Growth
- Family Life
- Relationships
- Mental Health
- Addiction
- Workplace Safety
- Career Transition
- Legal
- Pets

and much more!

SCAN ME

JBG

Download now at
www.jorgensenbrooks.com/app

NOTE:

- Employer number:
  - **Employer/Company Name**
- Password:
  - **JBG** *(not case sensitive)*

ALLIANCE

ON-THE-JOB INJURY?

If you sustained an on-the-job injury, and your injury is not life threatening or does not require immediate medical attention, contact the Alliance on-call triage nurse.

If you are an injured employee and have already received medical treatment, call the number on the right and press 3 to report the claim.

1 (888) CLAIM-89

(1-888-252-4689)

Available 24 hours a day, 7 days a week

ALLIANCE

¿LESIÓN EN EL TRABAJO?

Si sufrió una lesión en el trabajo, y su lesión no es potencialmente mortal o no requiere atención médica inmediata, póngase en contacto con la enfermera de triaje del Alliance.

Si usted es un empleado lesionado y ya han recibido servicios médicos, llame al número en la derecha y presione 3 para reportar la reclamación.

1 (888) CLAIM-89

(1-888-252-4689)

Disponible las 24 horas del día, los 7 días de la semana

Workman's Compensation-Employee Injury

- How To Report A Claim
    1. With the addition of the Nurse Triage Program, workers' compensation claims are no longer reported on the Alliance website.
    2. To report a workers' compensation claim, call the Alliance at 1-888-CLAIM-89 (1-888-252-4689) and Press 2 for the Alliance nurse triage if you have not obtained medical treatment. Press 3 to report a workers' compensation claim if treatment has been obtained. Employees with severe injuries should immediately seek medical treatment or call 9-1-1.
    3. A member of the Alliance support staff will submit the claim with you over the telephone. Please note that you will need details such as the injured employee's date of birth and date of hire.
    4. The on-call triage nurse line is available 24 hours a day, 7 days a week, and Alliance support staff is available from 7 a.m. to 5 p.m.
    5. When injured employees call in to speak with an on-call triage nurse, their supervisor and/or site nurse should also be on the call.
    6. If the injured employee has a minor injury, that does not need to be reported to the Alliance. District staff should instead complete the Supervisor's Incident Report with the injured employee.

Notes on Reporting Claims

7. All work-related injuries should be reported as soon as possible, but no later than ten (10) days after the date of injury.
8. Time-loss claims should be reported within twenty-four (24) hours.
9. Deaths must be reported immediately to the Alliance via telephone at 1-888-CLAIM-89 (1-888-252-4689), and to the Industrial Commission of Arizona (ICA) at (602) 542-1839.
10. Please note that as of January 1, 2015, employers are required to report the following to OSHA:

    - all work-related fatalities;
    - all work-related inpatient hospitalizations of one or more employees that occur within 24 hours of a work-related incident;
    - all work-related amputations; and
    - all work-related losses of an eye.

Work-related fatalities must be reported within eight hours of learning of them. Work-related inpatient hospitalizations of one or more employees; amputations; or losses of an eye that occur within 24 hours of a work-related incident must be reported within 24 hours of learning of them.

Some limitations to these requirements apply. For more information regarding the changes, please contact OSHA at (800) 321-OSHA (6742) or www.osha.gov.

The Adjustment Process

Once a new claim has been reported, the Alliance will investigate and manage the claim, up to and including the issuance of checks.

Upon receipt of a claim, the Alliance will begin an investigation to determine if the claim should be paid. The Alliance has twenty-one (21) days to accept or deny a claim from the date of the ICA notification.

Timely and accurate reporting of a claim is imperative to prevent improper claim denial, and to avoid compromising the member's right to successfully adjudicate a questioned claim.

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION

2024

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN

The 403(b) and 457(b) Plans are valuable retirement savings options. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) and 457(b) Plans offered.

Plan administration services for the 403(b) and 457(b) plans are provided by U.S. OMNI & TSACG Compliance Services. Visit the U.S. OMNI & TSACG Compliance Services' website *(https://www.tsacg.com)* for information about enrollment in the plan, investment product providers available, distributions, exchanges or transfers, 403(b) and/or 457(b) loans, and rollovers.

ELIGIBILITY

Most employees are eligible to participate in the 403(b) and 457(b) plans immediately upon employment; however, private contractors, appointed/elected trustees and/or school board members are not eligible to participate in the 403(b) Plan. Please verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans. Participants are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) and/or 457(b) account(s) up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) or 457(b) accounts are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. U.S. OMNI & TSACG Compliance Services monitors 403(b) and 457(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2024 IS $23,000.

Additional provisions allowed:

AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $7,500 to the 403(b) and/or 457(b) accounts. (varies based on "catch-up" provision)

ENROLLMENT

Employees who wish to enroll in the 403(b) and/or 457(b) plan must first select the provider and investment product best suited for their account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and/or a deferred compensation enrollment form and any disclosure forms must be completed and submitted to U.S. OMNI & TSACG Compliance Services. These forms authorize the employer to withhold 403(b) and/or 457(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. A SRA form and/or a deferred compensation enrollment form must be completed to start, stop or modify contributions to 403(b) and/or 457(b) accounts. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Please note: The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.

INVESTMENT PROVIDER INFORMATION
A current list of authorized 403(b) and 457(b) Investment Providers and current employer forms are available on the employer's specific Web page at *https://www.tsacg.com*.

PLAN DISTRIBUTION TRANSACTIONS
Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing. Prior to taking a loan, participants should consult a tax advisor.

PLAN-TO-PLAN TRANSFERS
A plan-to-plan transfer is defined as the movement of a 403(b) and/or 457(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

ROLLOVERS
Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS
Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations unless they have attained age 59½ or separated from service. Generally, a distribution cannot be made from a 457(b) account until you have reach age 59½ or have a severance from employment. In most cases, any withdrawals made from a 403(b) or 457(b) account are taxable in full as ordinary income.

EXCHANGES
Within each plan, participants may exchange account accumulations from one investment provider to another investment provider that is authorized under the same plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange. Exchanges can only be made from one 457(b) plan to another 457(b) plan, or from one 403(b) plan to another 403(b) plan.

403(b) and 457(b) PLAN LOANS
Participants may be eligible to borrow their 403(b) and/or 457(b) plan accumulations depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider.

HARDSHIP WITHDRAWALS
Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must certify and may be asked to provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at *https://www.tsacg.com*.

UNFORESEEN FINANCIAL EMERGENCY WITHDRAWAL
You may be able to take a withdrawal from your 457(b) account in the event of an unforeseen financial emergency. An unforeseeable emergency is defined as a severe financial hardship of the participant or beneficiary. The eligibility requirements to receive a Unforeseen Financial Emergency Withdrawal are provided on the Unforeseen Financial Emergency Withdrawal Disclosure form at *https://www.tsacg.com*.

EMPLOYEE INFORMATION STATEMENT
Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) and 457(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

PLAN ADMINISTRATOR CONTACT INFORMATION

Transactions
P.O. Box 4037 | Fort Walton Beach, FL 32549
Toll-free: 1-888-796-3786 | *https://www.tsacg.com*

For overnight deliveries
73 Eglin Parkway NE, Suite 202 | Fort Walton Beach, FL 32548
Toll-free: 1-888-796-3786 | *https://www.tsacg.com*

FREQUENTLY ASKED QUESTIONS

How do I enroll in Phoenix #1 benefits?

As a new hire, you have 31 days from your hire date to fill out your Benefits Election Forms and turn them in to the Benefits Department.

Am I required to enroll in all of the elections, or can I decline them?

You can elect to enroll or decline in any plan you would like. For example, you are able to enroll in the dental plan without enrolling in the medical plan, if desired.

When will my benefits begin?

The waiting period for benefits to start is the first of the month following your date of hire. For example, if you start with Phoenix #1 on July 20, your benefits will begin on August 1st. If your date of hire is August 1st, your benefits will begin on August 1st.

How long will I have coverage?

You will be covered until the end of the school year, June 30, 2024. You will have to re-elect your benefits in May 2025 for the next school year.

What if I want to make changes to my benefit elections during the year?

Phoenix #1's benefit plan year runs from July 1st through June 30th. The benefits you select during your initial eligibility period will be in effect until the end of the plan year and can only be changed during Phoenix #1 Open Enrollment period which takes place in May, or if you experience a Qualifying Life Event.