



BENEFITS ENROLLMENT GUIDE 2026 - 2027



DEER VALLEY
Unified School District



WELCOME

Welcome to **Deer Valley Unified School District's 2026 - 2027 Open Enrollment!** We encourage all insurance benefit-eligible employees to take an active role in their benefits enrollment and on an ongoing basis as you use your benefits throughout the coming year. This booklet includes information on the benefits available for election for 2026 - 2027. All employees must complete the 2026 - 2027 Open Enrollment process online. Depending on the elections you make, you may need to complete and return forms that can be found online on your benefits enrollment portal. Deer Valley's Open Enrollment is mandatory for all eligible employees, even if you are waiving benefits. If you do not log on and select benefits for the 2026 – 2027 plan year by 11:59 pm Arizona Time on May 8, 2026, your current benefits will end June 30, 2026.

WHAT'S INSIDE

Plan Rules	3
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Medical Benefits and more	6

ENROLLMENT CHECKLIST

- Review this guide with your loved ones. ☐
- Select the best plans for your needs and budget. ☐
- Ensure your dependent and beneficiary information is complete and correct. ☐
- Consider an annual contribution to an HSA if you enrolled in the HDHP plan. ☐

USING YOUR BENEFIT GUIDE

Our plan runs from July 1 to June 30, of each year. This guide provides a summary of benefit options to help you understand your benefit options and make the right decisions for you and your family – the first time. Keep a copy of this guide handy as it can be very useful when benefit-related questions or scenarios come up.

For even more information on your benefit options, scan the QR code or click [here](#) to view **Deer Valley Unified School District's 2026 - 2027 Open Enrollment Brainshark.**



WHAT'S CHANGED THIS YEAR

- Medical –Premium changes effective 7/1/2026 (See Premium Rate Sheet).
- Health Savings Account – IRS' maximum contribution limits have increased to \$4,400 for Individual and \$8,750 for Family. If 55+, you can contribute an additional \$1,000. Requires \$100 minimum employee contribution.
- EAP – New provider, ComPsych Guidance Resources, can be reached at 866.883.0874.
- ASRS - Contribution rate has decreased to 11.98% for the 2026-2027 school year.

Disclosure: This Benefit Enrollment guide is a brief overview solely for informational purposes. VSMG assumes no responsibility for any circumstances arising out of the use, misuse or interpretation of this guide. The Summary Plan Document (SPD) supersedes this benefit guide. Members should refer to the District's SPD for a description of benefits, limitations and exclusions. All services are subject to review for medical necessity. Members must be eligible at the time services are rendered.

PLAN RULES

BENEFITS ELIGIBILITY

Employees are eligible to participate in the District's benefit plans as of the first of the month following 30 days from the date your insurance eligible position begins. Employees must work at least 30 hours per week or .6 or higher FTE to participate in the District's benefit plans. Coverage for your dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner. Benefit eligible employees can enroll their eligible dependents in medical, dental, vision and voluntary life insurance.

Dependent children are defined as:

- Natural Child
- Stepchild
- Legally adopted child
- Child for whom you have legal guardianship
- Child for whom health care coverage is required through a "Qualified Medical Child Support Order"

Eligible dependents are defined as:

- Your legal spouse
- You or your spouse's dependent child(ren) under age 26
- Disabled adult child(ren) over age 26, unable to be self-supporting who remain a qualified tax-dependent

WHEN CHANGES ARE ALLOWED

The elections you make during this Open Enrollment will be effective from July 1, 2026, through June 30, 2027. All benefit plan deductibles are based on a calendar year.

Because some of the benefits you elect are offered on a pre-tax basis, the Internal Revenue Service (IRS) does not allow changes to these benefit elections outside of the annual Open Enrollment period unless you have a mid-year **Qualifying Life Event**. Please note that you must notify the Payroll & Benefits Specialist for your location within 30 days of your life event circumstance.

Common "Qualifying Life Events" include:

- Change in legal marital status.
- Change in number or status of dependents.
- Your dependent child no longer qualifying as an eligible dependent.
- Change in employee/spouse/dependent's employment status, work schedule or residence that affects their eligibility of benefits.
- Coverage of a child due to Qualified Medical Support Order.
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Loss of coverage of the employee or spouse's plan.
- Spouse's open enrollment or new hire enrollment period.

WHERE TO ENROLL

ENROLLMENT INSTRUCTIONS

Your personalized enrollment site can be accessed from any computer with an internet connection. You will be able to make your elections, changes, add or drop dependents, determine current coverage and changes

for the new plan year. Please note: Open Enrollment is the only time during the plan year that you may make changes to your benefits unless you experience a qualifying life event or a change in employment status.

HOW TO ENROLL

- Log into the Employee Access Portal at: <https://tyler-deervalleyusd97az.okta.com/>
- Go to **MyBenefits/Enrollment**. Follow the instructions on the screen.
- For each benefit, elect, change or waive coverage and then click on “Save Selection.”
- **Click on “Review & Submit” to review the information on your new elections. This is what you have chosen for the benefit year of July 1, 2026 – June 30, 2027.**
- Once you’re satisfied with your new elections, click on “Confirm & Submit”. You will receive a large thumbs up emoji. 🍑 Be sure to print a copy for your records.

IMPORTANT!

You must complete your online benefits enrollment by 11:59 pm Arizona Time on May 8th, 2026.

If you do not complete the enrollment process online, you will NOT have another opportunity to enroll, elect or change coverage until next year’s Open Enrollment period unless you have a permitted mid-year change in employment status and/or an approved qualifying event.



BENEFIT TERMINOLOGY

BENEFIT TERMINOLOGY

Terms and definitions to help you make informed decisions.

To assist you with your benefit decisions, review the below benefit terms and definitions as they can impact your care and your wallet.

— Premium

The amount you pay per-pay-period from your paycheck for your health insurance coverage.

— Deductible

A fixed, annual amount you pay for covered in-network health and prescription drug services before the health plan begins to pay. There are certain services, such as in-network preventive care, that are not subject to the deductible. Deductibles are different for individuals, families, and prescription drugs.

— Embedded Deductible

“Embedded” means individual deductibles are active within the larger, overall family deductible and can determine when coverage begins. For health plans with embedded deductibles, you need to satisfy his or her individual deductible for coverage and coinsurance to apply. When a family member on the health plan meets his or her individual deductible, plan benefits and coinsurance will apply to subsequent claims for that member.

— Non-Embedded Deductible

For health plans with non-embedded deductibles, the family deductible must be met before anyone in the family can receive benefits. The combined total of eligible expenses of all family covered members must equal the family deductible before any benefits are paid for any one member.

— Copay

A fixed dollar amount you will pay for covered services (health care and prescription drugs).

— Coinsurance

Your percentage cost share of covered health services and the health plan’s percentage cost share of covered health services, after you have met your deductible.

— In-Network

A group of doctors, hospitals, pharmacies and other providers that contract with UnitedHealthcare and provide services at the negotiated (discounted) rates. These plans only offer In-Network coverage.

— Out-of-Network

These plans do not have Out-of-Network coverage. The only exception is for emergency situations. In emergency situations, the Emergency Room would be subject to the plans’ Emergency Room copay.

— Out-of-Pocket (OOP) Maximum

The annual maximum you pay out-of-pocket before the health plan pays 100% for covered In-Network health services.

— Explanation of Benefits (EOB)

A statement from the health plan that describes how a medical or vision claim was paid or denied by the plan. The EOB includes the amount your provider billed the health plan for services, the amount not covered, discounts that saved you and the health plan money by using in-network providers, the amount paid by the health plan, and the amount you owe the provider, if any.

— Preauthorization

A review process by your health plan to make sure the services you will be receiving are medically-necessary and covered by the plan. Your provider’s office is responsible for starting the process. See the Summary Plan Document or access myuhc.com for procedures that require preauthorization.

CORE BENEFITS

CORE BENEFITS



In this section, we'll cover:

- Medical Overview
- Traditional PPO Plan
- HDHP Plan
- Virtual Care
- Health Savings Account
- Flexible Spending Account
- Wellness Program
- More Medical Benefits
- Dental
- Vision

MEDICAL BENEFITS

MEDICAL

When you enroll in one of the UnitedHealthcare (UHC) plans offered, you may visit any in-network provider, including specialists, without a referral. These plans are under the Choice Network. Please note that the District does NOT offer any out-of-network benefits. This means you MUST use an “IN-NETWORK” provider, facility or RX to ensure proper payment of benefits.

In the following pages, you’ll find a summary of each plan’s features. Be sure to review this information carefully. You can find more information on your benefits enrollment portal.



MAKE THE MOST OF YOUR BENEFITS

Take full advantage of your medical benefits by registering your account at uhc.com (click the link or scan the QR code) and downloading the mobile app. You’ll need to have your ID card handy to register.

Register
Online



Once registered, you can use this account to:

- View/print/order ID cards
- View medical claims and bills owed
- Monitor deductible and out-of-pocket limits
- Estimate costs of care
- Search for best providers

FIND THE RIGHT DOCTOR

If you want to find a doctor, hospital or provider office, there’s no need to log in! Instead, follow these simple steps:

Search
Providers



- Click [here](#) or scan the QR code
- Select “Type of Provider” then “Employer Plan”
- Select Plan: Choice
- Type in your address or ZIP code
- Select which type of provider
- Click “search” for a listing

TRADITIONAL PPO PLAN

MEDICAL



MEDICAL CARE - WHAT YOU PAY	IN-NETWORK	OUT-OF-NETWORK
Deductible (Calendar Year) - Individual / Family	\$1,250 / \$3,500	N/A
Out-of-Pocket Max (Calendar Year) - Individual / Family	\$5,000 / \$10,000	N/A
Co-Insurance	You pay 20%	N/A
Preventative (Annual Wellness Visit)	\$0	Not covered
Virtual Visit	\$0	Not covered
PCP Visit	\$25 copay	Not covered
Specialist Visit	\$50 copay	Not covered
Labs – X-Rays and Bloodwork / Major Diagnostics	\$0 / \$100 copay	Not covered
Urgent Care	\$75 copay	Not covered
Emergency Room	\$250 copay	\$250 copay
Surgery or Hospital Stay	Subject to Deductible and Co-Insurance	Not covered

PRESCRIPTIONS	COST
Retail (30-day supply)	
Tier 1 (Low Cost)	\$10 copay
Tier 2 (Mid-Range)	\$35 copay
Tier 3 (Higher Cost)	\$60 copay
Mail Order (90-day supply)	
Tier 1 (Low Cost)	\$25 copay
Tier 2 (Mid-Range)	\$87.50 copay
Tier 3 (Higher Cost)	\$150 copay



View the
Current
Prescription
Drug List



Your prescription coverage through OptumRX continues with the Valley Pharmacy Network. This allows both the district and the covered members to save money with deeper negotiated discounts at specific pharmacies including Walgreens, Rite Aid, Walmart, Sam's Club and Fry's.

HDHP PLAN

MEDICAL



MEDICAL CARE - WHAT YOU PAY	IN-NETWORK	OUT-OF-NETWORK
Deductible (Calendar Year) - Individual / Family	\$3,400 / \$6,800 (Embedded)	N/A
Out-of-Pocket Max (Calendar Year) - Individual / Family	\$5,000 / \$10,000	N/A
Co-Insurance	You pay 20%	N/A
Preventative (Annual Wellness Visit)	\$0	Not covered
Virtual Visit	\$0*	Not covered
PCP Visit	Subject to Deductible and Co-Insurance	Not covered
Specialist		
Labs & Major Diagnostics		
Urgent Care		
Hospital Stay		
Emergency Room	Subject to Deductible and Co-Insurance	Subject to Deductible and Co-Insurance

*No charge by a Designated Virtual Network Provider. Office visit cost share applies to any other Telehealth service based on provider type.



PRESCRIPTIONS	COST
Retail (30-day supply)	
Tier 1 (Lower Cost)	\$10 copay
Tier 2 (Mid-Range Cost)	\$35 copay
Tier 3 (Higher Cost)	\$60 copay
Mail Order (90-day supply)	
Tier 1 (Lower Cost)	\$25 copay
Tier 2 (Mid-Range Cost)	\$87.50 copay
Tier 3 (Higher Cost)	\$150 copay

Your prescription coverage through OptumRX continues with the Valley Pharmacy Network, allowing you to save money with deeper negotiated discounts at specific pharmacies including Walgreens, Rite Aid, Walmart, Sam's Club and Fry's. You are subject to your \$3,400 / \$6,800 Medical / Pharmacy deductible before copays apply. Medications listed on Expanded Preventative Drug List are subject to copays prior to meeting your deductible. Select contraceptives are available at no cost.

IMPORTANT!

Employees who enroll in the HDHP with HSA plan will receive a District-funded Health Savings Account (HSA) contribution of 2x times the employee contribution, up to \$1,200 maximum. Examples below.

If you contribute \$500 to your HSA, the District will contribute \$1,000 to your HSA.

If you contribute \$1,000 to your HSA, the District will contribute \$1,200 to your HSA since the District's maximum contribution is \$1,200.

Employees must contribute a minimum of \$100 annually to their HSA to receive the District's contribution. Funds will be deposited during the 2026 - 2027 plan year. If you are on Medicare, you can elect HDHP Plan, but you CANNOT fund a Health Savings Account per IRS regulations.

View the
Current
Prescription
Drug List



VIRTUAL CARE

24/7 DOCTOR VISITS

With UHC 24/7 Virtual Visits, you can connect to a provider by phone or video (data rates may apply) through myuhc.com® or the UnitedHealthcare® app. Providers can treat a wide range of health conditions including many of the same conditions treated in an emergency room (ER) or urgent care facility and may prescribe medications when needed.

Save money and time!

Consider 24/7 Virtual Visits with a Designated Virtual Network Provider for these common conditions and more:

- Cough
- Headache
- Sore throat
- Fatigue/weakness
- Nasal discharge
- Difficulty sleeping
- Congestion
- Sinus Pain
- Fever
- Loss of appetite

UHC MEDICAL PLAN ENROLLMENT	COST PER VISIT
Traditional Choice Plus PPO Plan	No Charge
HDHP Choice Plus PPO Plan	No Charge*

*No charge by a Designated Virtual Network Provider. Office visit cost share applies to any other Telehealth service based on provider type.

Get specialized treatment and support!

Utilize 24/7 Virtual Visits for these specialties*:

- Women's Health
- Dermatology
- Gastroenterology
- Sleep care
- Cardiac rehab and more

*Copays and deductibles may apply.

VIRTUAL CARE



To get started, scan the QR code to sign in to your account.



You can also click [here](#) or call 866.801.4409.

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.

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 \$54; \$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 is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. 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.

HEALTH SAVINGS ACCOUNT (HSA)

If you are enrolled in the HDHP plan, you can contribute to a Health Savings Account (HSA) with OptumBank, a personal savings account that lets you set aside pre-tax money from your paycheck to use on qualified medical expenses. Some examples of qualified expenses include deductibles and copays, doctor's office visits, prescription drugs, vaccines, screenings, and more!

Employees who enroll in the HDHP with HSA plan will receive an annual District-funded Health Savings Account (HSA) contribution of 2x times the employee contribution, up to \$1,200 maximum.

The District's contribution to a HDHP plan participant's HSA account is deposited in equal increments over 21, 22, or 24 pay periods during the plan year. If you choose to make voluntary contributions, those contributions are deducted from your pay, over your remaining deductions once your account is activated. There is an annual minimum contribution of \$100 if you choose to contribute to an HSA.

HOW MUCH CAN I CONTRIBUTE?

To calculate, simply subtract the District's annual contribution from the IRS 2026 annual maximum contribution limits below.

COVERAGE TIER	MAXIMUM AMOUNT
Individual	\$4,400
Family	\$8,750
Age 55+	Additional \$1,000

Note: The applicable service fee of \$1.00 to \$3.00 is automatically deducted by OptumBank from your HSA balance each month depending on your account selection and balance.

TAX-SAVINGS

Optum Bank®
Member FDIC

THE BENEFITS

Triple Tax Savings

The **only** account where contributions are tax deductible; the funds grow with no tax liability; and money used for health expenses is not taxed upon withdrawal.

You Own it

The account is yours! You use the funds like you would a bank account. You can take the account and the funds in it if you leave the District or retire.

Growth Potential

The funds in the account can be invested and earnings grow tax-free. After age 65, you can use the HSA like a traditional retirement account.

Dependent Use

The funds in the account can be used for your dependents expenses as well, regardless of whether they are enrolled in an HDHP plan.

HOW DO I CONTRIBUTE?

You can contribute pre-tax dollars to an individual Health Savings Account on your portal during your enrollment. If you are on Medicare, you can elect the HDHP plan, but you cannot contribute to an HSA. **NOTE:** If you have questions, please contact the Benefits Department for more details.

View the
Full List of
HSA Qualified
Expenses





FLEXIBLE SPENDING ACCOUNT (FSA)

A Flexible Spending Account (FSA) is an account that allows you to set aside pre-tax money from your paycheck to pay for certain expenses. You can use FSAs to pay for out-of-pocket health care costs such as insurance deductibles and copayments, qualified prescription drugs, insulin, and medical devices. You can also use FSAs for dependent care expenses, such as childcare services.

MAKING YOUR ANNUAL FSA ELECTION

The IRS requires you to elect your FSA contributions every year. If you wish to participate, you need to make your 2026 - 2027 election during Open Enrollment or your initial benefit enrollment period. Any unused dollars from your current contribution will carry over up to \$680. You can only enroll during open enrollment or your initial benefit period.

HOW MUCH CAN I CONTRIBUTE?

Contributions must be spent in the current insurance year. If you choose to enroll, your contribution will be deducted from your pay in equal increments from July 1, 2026 – June 30, 2027 on pre-tax basis.

ACCOUNT TYPE	2026 IRS CONTRIBUTION LIMITS
Medical FSA	\$3,400
Allowable rollover	\$680
Limited FSA	\$3,400
Allowable rollover	\$680
Dependent Care FSA	\$7,500

If you choose to enroll in the HDHP plan and contribute to the Medical Expense Reimbursement Account, you can use your funds on a “limited purpose” basis – to pay your eligible dental and vision care expenses only.

IMPORTANT!

DON'T FORGET THE “USE IT OR LOSE IT” RULE

The IRS governs the administration of Flexible Spending Account plans, and once you elect to set aside money in an FSA, you must use it for eligible expenses during the plan year. You should make every effort to file your FSA claims as you incur expenses.

You may carry over up to \$680 of unused amounts remaining in your Medical FSA or Limited FSA at the end of a Plan Year to be used for Medical Care Expenses incurred during the next Plan Year, beginning with any unused amounts remaining at the end of the current Plan Year. No more than \$680 of your unused Medical FSA or Limited FSA amount for a Plan year may be carried over for use in the next plan year. NOTE: The carryover does not apply to the Dependent Care FSA.

However, you have a 90-day runout period after the plan year ends (June 30) to file claims for reimbursement. After that point, you forfeit, or “lose,” any unused funds above \$680. Because of this IRS “use it or lose it” rule, be sure to carefully estimate the amount you want to contribute to the FSAs before making your elections.

WELLSTYLES

WELLNESS



WellStyles is on a mission to help you feel healthier and happier. All employees can take advantage of this dedicated Wellness program at no cost!

Sign-up for newsletters, take on group challenges, and earn up to \$200 in gift cards for being healthy!

HOW IT WORKS

- Sync Up**
To fitness devices and apps.
- Team Up**
Connect online with friends and family.
- Step It Up**
Join a wellness challenge!
- Measure Up**
Set goals and track your results.
- Rack Up**
Earn incentives along the way!
- Live It Up**
Improve your overall health and wellbeing!



FEATURES

- Wellness Challenges
- Connecting with co-workers
- Syncing devices and apps
- Incentives
- Healthy habits
- Gym discounts
- Newsletters
- Digital workouts
- Meditations
- Webinars



MORE MEDICAL BENEFITS

MORE BENEFITS

Those enrolled in one of the District's medical plans have access to additional programs designed to support your health and wellbeing every step of the way. Scan the QR code to access these benefits on the Benefits page within the WellStyles platform, powered by Personify Health.

Scan
me!



Click [here](#)



Hinge Health gives you the tools you need to conquer back and joint pain, recover from injuries, prepare for surgery, and stay healthy and pain free. This program is available to employees and dependents 18+ on the UHC medical plan through their employer.



2nd.MD connects you with a board-certified specialist for an expert second opinion via phone or video at no cost. This program is available to employees and their dependents on the UHC medical plan.



Parsley Health finds the root cause of your symptoms and makes a personalized plan for healing with online support every step of the way. The program is available to employees and dependents 18+ on the UHC medical plan.



Maven Clinic offers comprehensive maternity and postpartum services. Maven is free to employees, spouses, and/or dependents (18+) who are on the UHC plan through their employer.



Calm Health empowers individuals to navigate life's twists and turns with evidence-based programs and mindfulness content designed for maximizing engagement.



DENTAL PPO PLAN

DENTAL



BENEFITS PAYABLE	PPO DENTIST	PREMIER DENTIST	OUT-OF-NETWORK
Annual Maximum Benefit (Combination of in/out-of-network)	\$1,500	\$1,000	\$1,000
Lifetime Orthodontia Maximum (Combination of in and out-of-network)	\$1,000	\$750	\$750
Annual Deductible (Individual/Family) (Combination of in and out-of-network)	\$25 / \$75	\$50 / \$150	\$50 / \$150
PREVENTATIVE SERVICES			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers Sealants - to prevent decay of permanent teeth Radiographs - X-rays Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
BASIC SERVICES			
Emergency Palliative Treatment - temporary pain relief Minor Restorative Services – fillings Endodontic Services - root canals Periodontic Services - to treat gum disease Oral Surgery Services - surgical extractions Other basic – misc services	80%	70%	70%
MAJOR SERVICES			
Crown Repair – to individual crowns Major Restorative Services – crowns Relines and Repairs - to bridges and dentures Prosthodontic Services - bridges, implants, dentures	50%	50%	50%
ORTHODONTIC SERVICES			
Benefit for dependent children ages 8–25. Payable in two payments - upon initial banding and 12 months after. The Orthodontia lifetime maximum is separate from the annual maximum for your other dental benefits.	50%	50%	50%

View a list of
Participating
Providers



Predetermination recommended for services over \$250. Please Note: When you receive services from a Delta Dental Premier or Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule (or the Nonparticipating Dentist Fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and you are responsible for that difference.

DENTAL DHMO PLAN

DENTAL



Enjoy peace of mind with pre-paid dental coverage. With the Cigna Dental DHMO plan, you must select and visit your primary care dentist in the Cigna network in order to receive benefits. The directory of in-network dental care providers in Cigna is available on their site. Make sure that the dentist that you want is accepting new patients.

Cigna DHMO coverage has a predetermined cost that you will pay. Services include preventative, basic, major services, and orthodontia for adults and children. There are no claim forms or calendar year maximum with the Cigna DHMO plan. Refer to the schedule of benefits to view your coverage and cost for services at www.mycigna.com or by calling 1-800-244-6224.

BENEFIT FEATURES

- Lowest premiums!
- No deductibles or maximums for covered services.
- Pay for services at a discounted rate!
- Orthodontia discount included.

SERVICES COVERED

- Diagnostic
- Preventive
- Restorative
- Endodontics
- Periodontics
- Prosthodontics
- Oral surgery
- TMJ
- Orthodontics

For more information and a detailed listing of covered procedures, scan the QR code to download the guide, call 800.Cigna24 or visit cigna.com



View
Guide



Find
Dentists



VISION BASE PLAN



IN-NETWORK SERVICES	WHAT YOU PAY	FREQUENCY
VISION EXAM	\$10 copay	every 12 months
MATERIALS	\$25 copay	every 12 months
RETINAL SCREENING	up to \$39	every 12 months
FRAMES Private Practice Provider Retail (Walmart, Sam's Club, Costco) Featured Brands	\$160 allowance \$160 allowance \$180 allowance	every 24 months
LENSES Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children (up to age 19) Enhancements Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses Scratch-resistant Coating	covered by materials copay \$0 \$95 - \$105 \$150 - \$175 \$0	every 12 months
CONTACT LENSES (IN LIEU OF GLASSES) Allowance is applied toward the purchase of contact lenses. Materials copay is waived.	\$150 allowance	every 12 months

OUT-OF-NETWORK REIMBURSEMENT	WHAT YOU GET
EXAM(S)	up to \$45
FRAMES	up to \$70
LENSES Single Vision Lenses Lined Bifocal Lenses Lined Trifocal Lenses Progressive Lenses	up to \$30 up to \$50 up to \$65 up to \$50
CONTACT LENSES (IN LIEU OF GLASSES)	up to \$105

View a
List of
Participating
Providers



Click [here](#)

Exclusive Member Extras for VSP Members

Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers.

Save up to 60% on digital hearing aids with TruHearing®. Visit vsp.com/offers/special-offers/hearing-aids for details.

Enjoy everyday savings on health, wellness, and more with VSP Simple Values.

VISION BUY-UP PLAN



IN-NETWORK SERVICES	WHAT YOU PAY	FREQUENCY
VISION EXAM	\$10 copay	every 12 months
MATERIALS	\$10 copay	every 12 months
RETINAL SCREENING	up to \$39	every 12 months
FRAMES Private Practice Provider Retail (Walmart, Sam's Club, Costco) Featured Brands	\$225 allowance \$225 allowance \$245 allowance	every 12 months
LENSES Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children (up to age 19) Enhancements Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses Scratch-resistant Coating UV Protection	covered by materials copay \$0 \$40 \$40 \$0 \$0	every 12 months
CONTACT LENSES (IN LIEU OF GLASSES) Allowance is applied toward the purchase of contact lenses. Materials copay is waived.	\$175 allowance	every 12 months

OUT-OF-NETWORK REIMBURSEMENT	WHAT YOU GET
EXAM(S)	up to \$45
FRAMES	up to \$70
LENSES Single Vision Lenses Lined Bifocal Lenses Lined Trifocal Lenses Progressive Lenses	up to \$30 up to \$50 up to \$65 up to \$50
CONTACT LENSES (IN LIEU OF GLASSES)	up to \$105

View a
List of
Participating
Providers



Click [here](#)

Exclusive Member Extras for VSP Members

Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers.

Save up to 60% on digital hearing aids with TruHearing®. Visit vsp.com/offers/special-offers/hearing-aids for details.

Enjoy everyday savings on health, wellness, and more with VSP Simple Values.

PREMIUM RATES

PREMIUM RATES

UHC TRADITIONAL PPO (PRIOR TO 7/1/2012)	EMPLOYEE MONTHLY	EMPLOYEE ANNUAL
Employee	\$50.00	\$600.00
Employee + Spouse	\$1,027.95	\$12,335.40
Employee + Child(ren)	\$688.34	\$8,260.08
Family	\$1,112.84	\$13,354.08
Dual Spouse	\$210.84	\$2,530.08
UHC TRADITIONAL PPO (AFTER 7/1/2012)	EMPLOYEE MONTHLY	EMPLOYEE ANNUAL
Employee	\$80.00	\$960.00
Employee + Spouse	\$1,080.95	\$12,971.40
Employee + Child(ren)	\$741.34	\$8,896.08
Family	\$1,165.84	\$13,990.08
Dual Spouse	\$270.84	\$3,250.08
UHC HDHP BASIC	EMPLOYEE MONTHLY	EMPLOYEE ANNUAL
Employee	\$0.00	\$0.00
Employee + Spouse	\$835.31	\$10,023.72
Employee + Child(ren)	\$550.36	\$6,604.32
Family	\$906.53	\$10,878.36
Dual Spouse	\$112.88	\$1,354.56
DELTA DENTAL PPO	EMPLOYEE MONTHLY	EMPLOYEE ANNUAL
Employee	\$0.00	\$0.00
Employee + Spouse	\$32.86	\$394.32
Employee + Child(ren)	\$36.15	\$433.80
Family	\$65.72	\$788.64
CIGNA DENTAL DHMO	EMPLOYEE MONTHLY	EMPLOYEE ANNUAL
Employee	\$0.00	\$0.00
Employee + Spouse	\$0.00	\$0.00
Employee + Child(ren)	\$0.00	\$0.00
Family	\$0.00	\$0.00
VOLUNTARY VISION – VSP BASE	EMPLOYEE MONTHLY	EMPLOYEE ANNUAL
Employee	\$6.08	\$72.96
Employee + Spouse	\$12.17	\$146.04
Employee + Child(ren)	\$13.02	\$156.24
Family	\$20.81	\$249.72
VOLUNTARY VISION – VSP BUY-UP	EMPLOYEE MONTHLY	EMPLOYEE ANNUAL
Employee	\$11.78	\$141.36
Employee + Spouse	\$23.55	\$282.60
Employee + Child(ren)	\$25.20	\$302.40
Family	\$40.27	\$483.24

MORE BENEFITS

MORE BENEFITS



Wait, there are more benefits for you and your loved ones to choose from! In this section, we'll cover:

- Life and Accidental Death & Dismemberment
- Short-Term Disability
- Employee Assistance Programs
- Important Contacts

LIFE AND AD&D

LIFE AND AD&D

Life insurance provides basic protection for your loved ones if something happens to you. Taking advantage of life insurance coverage offered by Deer Valley USD can be an important part of your financial security.



BASIC (EMPLOYER PAID) LIFE INSURANCE

The District provides eligible employees (30 hours a week or .6 FTE) with life insurance equivalent to the greater of 1x your annual salary or \$20,000, up to a maximum of \$150,000. This benefit is provided to you at no cost! Please note that benefits are reduced to 50% at age 70. Your coverage ends at termination of your employment.

SUPPLEMENTAL (EMPLOYEE PAID) LIFE INSURANCE

Employees can buy supplemental life insurance for themselves and their dependents. The amounts you can elect are based upon the following:

WHO IS COVERED	AVAILABLE COVERAGE AMOUNTS
Employees Earning less than \$50,000 / year Earning more than \$50,000 / year	Initial Guarantee Issue*: \$150,000 \$10,000 - \$250,000 in \$10,000 increments (not to exceed 5x annual earnings) \$10,000 - \$500,000 in \$10,000 increments (not to exceed 5x annual earnings)
Spouse	Initial Guarantee Issue*: \$30,000; \$5,000 to \$150,000 in \$5,000 increments
Child(ren)	Guarantee Issue: \$10,000; \$2,000 to \$10,000 in \$1,000 increments

**Initial Guarantee Issue is available to newly hired or and newly eligible employees and dependents only. Please note that life insurance may have exclusions and limitations and/or require Evidence of Insurability (not required for Child(ren) coverage). Please see plan details for more information.*

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Employees can buy supplemental AD&D insurance for themselves and their dependents, which can be elected independent of supplemental Life insurance. The amounts you can elect are based upon the following:

WHO IS COVERED	AVAILABLE COVERAGE AMOUNTS
Employees	\$10,000 - \$500,000 in \$10,000 increments (not to exceed 5x annual earnings)
Spouse	\$5,000 to \$250,000 in \$10,000 increments
Child(ren)	\$1,000 to \$10,000 in \$1,000 increments

SHORT-TERM DISABILITY

SHORT-TERM DISABILITY

Short-term disability insurance provides income protection if you are unable to work due to a non-occupational injury or illness. It replaces a portion of your total weekly earnings (66.67%), less any income that was actually paid to you

from other sources for the same disability. This plan can provide you with a weekly cash benefit to help you pay for everyday expenses such as mortgage/rent, utilities, childcare, or groceries while you are on the road to recovery.

Employer-paid coverage is provided by the District at no cost to you!



After your claim is approved, you will begin receiving benefits (66.67% up to \$500 per week) as soon as 91 days from the date you are unable to work due to an off-job injury or illness (this

duration is referred to as the “elimination period/waiting period”) for up to 13 weeks. Please note that there is a 12-month waiting period for pre-existing conditions.

EMPLOYER-PAID COVERAGE	ELIMINATION PERIOD	BENEFIT DURATION
Accident-related	91 days	up to 13 weeks
Illness-related (including maternity)	91 days	up to 13 weeks

VOLUNTARY SHORT-TERM DISABILITY

Employees can buy voluntary short-term disability insurance to help bridge the gap between the onset of their disability and the elimination period of 91 days.

With voluntary short-term disability, benefits will begin paying as soon as 15 days from a disability due to an off-job accident or illness including maternity and are payable for up to 11 weeks. Please note that there is a 12-month waiting period for pre-existing conditions. You will see pricing for this benefit in your enrollment portal.

EMPLOYEE-PAID COVERAGE	ELIMINATION PERIOD	BENEFIT DURATION
Accident-related	15 days	up to 11 weeks
Illness-related (including maternity)	15 days	up to 11 weeks

PRE-EXISTING CONDITION LIMITATIONS

The policy does not pay benefits for disabilities that begin within 12 months of your initial enrollment in the plan if you received medical treatment, consultation, care, or service (including diagnostic measures), or took prescribed drugs or medicines for the disabling condition during the 12 months prior to your effective date. To be eligible for coverage during pregnancy, you cannot be pregnant before your benefit effective date (e.g., July 1, 2026) if you are enrolling during 2026 – 2027 Open Enrollment).

EMPLOYEE ASSISTANCE PROGRAMS

The District offers all employees access to help for life's challenges including legal, financial and work/life resources. Issues commonly addressed through your EAP benefits include:

- Family conflict - divorce, custody, blended family, domestic violence issues.
- Grief - accidents, illness, victim of crime, loss of a loved one.
- Changes- relocation, job stress, interpersonal problems, communication issues, empty nest, aging parents.
- Personal growth - interpersonal skills (relationship and/or communication) for work or family.
- Dependence or codependence issues - alcohol, drugs, gambling.



AVAILABLE FREE TO ALL EMPLOYEES

A comprehensive identity theft monitoring service that alerts you at the first sign of fraud and fully restores your identity. This service is automatically provided to you by the District at no additional cost. You may add family coverage for just \$8.95/month. If you do not wish to obtain this coverage, simply decline the coverage at time of open enrollment or when you become benefit eligible.

Call 800.789.2720

Scan Here



NEW AND AVAILABLE FREE TO ALL EMPLOYEES AND DEPENDENTS

With ComPsych GuidanceResources, employees and their dependents have access to up to six (6) free, confidential in-person or teletherapy sessions, per problem, per family member. ComPsych services include legal, financial and work/life resources. To get started, scan the QR code or click [here](#), and enter "Web ID: VALLEY" followed by the first 5 characters of your employer's name.

Call 866.883.0874

Register Now



AVAILABLE FREE TO ALL MEDICAL PLAN PARTICIPANTS

UnitedHealthcare EAP is confidential and provided at no additional cost to medical plan participants (employees and dependents). UnitedHealthcare EAP, a 24-hour referral service, is staffed with master's level counselors who can help with almost any problem ranging from medical and family matters to personal, legal, financial, and emotional issues. You can meet with a counselor anytime, day or night, 7 days a week, 365 days a year. Members can access 3 in-person visits with an in-network counselor at no out-of-pocket expense per incident.

Call 866.314.8187
Español 866.314.8187

Scan Here



IMPORTANT CONTACTS

IMPORTANT CONTACTS

Medical: UnitedHealthcare

myuhc.com

Customer Service: 800.638.7287

EAP: 888.887.4114

Virtual Visits: UnitedHealthcare

myuhc.com/virtualvisits

855.615.8335

Health Savings Account (HSA): Optum

optumhealthbank.com

800.791.9361

Flexible Spending Accounts (FSA): WEX

wexinc.com

866.451.3399

Wellness: WellStyles

enroll.personifyhealth.com

Second Opinion Consultation: 2nd.MD

2nd.md.com

Virtual Physical Therapy: Hinge Health

hingehealth.com

**Enter: Valleyschools in the employer/health plan field*

Root Cause Medicine: Parsley Health

parsleyhealth.com

Maternity & Postpartum: Maven

mavenclinic.com

Mental Health & Mindfulness: Calm Health

myuhc.com

**Login and click on "benefits" and then "self-care and coaching"*

Dental: Delta Dental

deltadentalaz.com

602.938.3131

Option1, State of AZ

Toll Free Hotline:

866.978.2839

Dental: Cigna

mycigna.com

800.Cigna24

Vision: VSP

vsp.com

800.877.7195

Life, AD&D, and Short-Term Disability: SunLife

sunlife.com

800.247.6875

EAP: ComPsych GuidanceResources

guidanceresources.com

Web ID: VALLEY

TRS: Dial 711

866-883-0874

EAP: Allstate Identity Protection

myaip.com

800.789.2720

Arizona State Retirement System (ASRS)

azasrs.gov

602.240.2000

Deer Valley Unified School District

Employee Benefits Office

Laura Nelson, Benefits Specialist

Phone: 623.445.5032



DEER VALLEY
Unified School District



VSMG
BETTER ADVICE. BETTER BENEFITS





The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-638-7287 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$1,250 Individual / \$3,500 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : \$5,000 Individual / \$10,000 Family Per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a <u>network provider</u>?	Yes. See myuhc.com or call 1-800-638-7287 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	24/7 Virtual visits - No Charge by a Designated Virtual <u>Provider</u> . If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> per service, <u>deductible</u> does not apply.	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$10 <u>copay, deductible</u> does not apply. Mail-Order: \$25 <u>copay, deductible</u> does not apply.	Not Covered	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 90 day supply, copay applies to each 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a requirement or may result in a higher cost. If you use a non- <u>network</u> pharmacy <u>preauthorization</u> (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 <u>copay, deductible</u> does not apply. Mail-Order: \$87.50 <u>copay, deductible</u> does not apply.	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$60 <u>copay, deductible</u> does not apply. Mail-Order: \$150 <u>copay, deductible</u> does not apply.	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> per visit, <u>deductible</u> does not apply.	\$250 <u>copay</u> per visit, <u>deductible</u> does not apply.	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Urgent care</u>	\$75 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	20% <u>coinsurance</u>	Not Covered	See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	Limited to 60 visits per calendar year.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits.
	<u>Habilitative services</u>	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Limited to 1 exam every 2 years.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
- Acupuncture - Bariatric surgery - Cosmetic surgery - Dental care	- Glasses - Infertility treatment - Long-term care - Non-emergency care when travelling outside - the U.S.	- Private duty nursing - Routine foot care – Except as covered for Diabetes - Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
Chiropractic (Manipulative care) – 20 visits per calendar year	Hearing aids - \$2,500 per calendar year	Routine eye care (adult) - 1 exam per 2 years

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-638-7287.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-638-7287.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-638-7287.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-638-7287.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,250
■ <u>Specialist</u> copay	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,250
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,140

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,250
■ <u>Specialist</u> copay	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$30
The total Joe would pay is	\$1,430

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,250
■ <u>Specialist</u> copay	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,150

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزاي والتغطية هذا. (Summary of Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage- SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánílti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shqódi Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béesh bee hane'í biká'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-314-8187 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$3,400 Individual / \$6,800 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : \$5,000 Individual / \$10,000 Family Per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See myuhc.com or call 1-866-314-8187 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	Not Covered	24/7 Virtual visits - No Charge by a Designated Virtual Network Provider.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$10 <u>copay</u> Mail-Order: \$25 <u>copay</u>	Not Covered	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 90 day supply, copay applies to each 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a requirement or may result in a higher cost. If you use a non- <u>network</u> pharmacy <u>preauthorization</u> (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied. Prescription drug costs are subject to the annual <u>deductible</u> . Copays only apply to covered prescription drugs on the Expanded Preventive Drug List. All other prescription drugs are subject to deductible and coinsurance. Once the deductible is met, copays apply to all covered prescription drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 <u>copay</u> Mail-Order: \$87.50 <u>copay</u>	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$60 <u>copay</u> Mail-Order: \$150 <u>copay</u>	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Not Covered	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	20% <u>coinsurance</u>	Not Covered	See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	Limited to 60 visits per calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not Covered	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Habilitative services</u>	20% <u>coinsurance</u>	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	Not Covered	Limited to 1 exam every 2 years.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
- Acupuncture - Bariatric surgery - Cosmetic surgery - Dental care	- Glasses - Infertility treatment - Long-term care - Non-emergency care when travelling outside - the U.S.	- Private duty nursing - Routine foot care – Except as covered for Diabetes - Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
Chiropractic (Manipulative care) – 20 visits per calendar year	Hearing aids - \$2,500 per calendar year	Routine eye care (adult) - 1 exam per 2 years

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-314-8187.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-314-8187.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-314-8187.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-314-8187.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist</u> copay	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,300
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,760

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist</u> copay	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,400
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$70
What isn't covered	
Limits or exclusions	\$30
The total Joe would pay is	\$4,200

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist</u> copay	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: [UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزاي والتغطية هذا. (Summary of Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage- SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

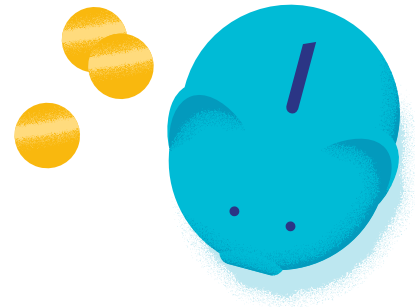
PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániit'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqódi Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíik'ehgo béesh bee hane'í biká'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

Use an HSA to pay for hundreds of health and wellness essentials

A health savings account (HSA) can be used to pay for many covered health care services and products for yourself, your spouse and even tax dependents. It can also be used to pay for many other health care services and items that may not be covered by your health plan.



Qualified HSA expenses include:

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs
- Artificial teeth
- Blood sugar test kits for diabetics
- Breast pumps and lactation aids
- Certain over-the-counter drugs and medications
- Chiropractor
- Contact lenses and solutions
- Crutches
- Dental treatments including X-rays, cleanings, fillings, braces and tooth removals
- Doctor's office visits and procedures
- Drug addiction treatment
- Drug prescriptions
- Eyeglasses and vision exams
- Fertility treatment
- Health plan deductibles and copayments
- Health plan premiums for COBRA plans, long-term care insurance and health continuation insurance while receiving unemployment benefits
- Hearing aids and batteries
- Hospital services
- Insulin
- Laboratory fees
- Laser eye surgery
- Long-term care services (limited)
- Menstrual care products
- Physical therapy
- Psychiatric care if the expense is for mental health care provided by a psychiatrist, psychologist or other licensed professional
- Special education for learning disabilities
- Speech therapy
- Stop-smoking programs including nicotine gum or patches
- Surgery, excluding cosmetic surgery
- Tampons and pads
- Vasectomy
- Walker
- Weight-loss program if it is a treatment for a specific disease diagnosed by a physician
- Wheelchair

This is not a complete list

The Internal Revenue Service (IRS) decides which expenses can be paid from an HSA and can change the list at any time.

HSA's can't be used to purchase the following health care services and items:

- Costs or expenses reimbursed from another source, such as health coverage or a flexible spending account
- Cosmetic surgery
- Diaper service
- Electrolysis or hair removal
- Health club dues
- Household help
- Maternity clothes
- Nutritional supplements, such as multi-vitamins, for general good health
- Personal use items, such as toothbrush, toothpaste, etc.
- Swimming lessons
- Teeth whitening



Know the penalty

If an HSA is used to pay for care or services that is not a "qualified medical expense," you will have to pay a 20% penalty, plus taxes on the money spent. For example, if the expense was \$100, the penalty would be another \$20, plus taxes. This penalty does not apply if you are 65 or older.



Keep your receipts

Keep all records of your medical expenses in case of an IRS audit. That way, you can prove that your HSA was used for qualified expenses.



See your coverage details

If you have a health plan with an HSA, visit myuhc.com® to see your coverage details or call the phone number listed on your health plan ID card.

What does that mean?

Search the Just Plain Clear® Glossary for thousands of health care terms defined in plain, clear language. Visit justplainclear.com.

Learn more

Visit [IRS.gov](https://irs.gov) for more information on HSAs and qualified expenses



The UnitedHealthcare plan with Health Savings Account (HSA) high deductible health plan (HDHP) is designed to comply with IRS requirements so eligible enrollees may open a Health Savings Account through Optum Bank, Member FDIC. The "HSA" refers generally to the UnitedHealthcare HSA product, which includes a HDHP, although at times "HSA" may refer only and specifically to the UnitedHealthcare Health Savings Account, provided in conjunction with Optum Bank and not to the associated HDHP.

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

Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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> Medical FSA

Why should I choose a medical flexible spending account?

A medical FSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses. This saves you money by reducing your taxable income.



Funds on Day 1

Schedule that surgery, buy those eyeglasses or finally get those braces. All of your FSA funds are available to spend right away. Use your benefits debit card at the point of purchase.



Discount

Think of it like a discount on healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens and more. Dollars you contribute are taken out of your paycheck before tax which means a \$100 purchase would actually cost you over \$130 without a medical FSA.*



Plan ahead

Think about the money you spent on healthcare expenses last year. Plan ahead and set those funds aside in a medical FSA and save 30%.*

*Based on a 30% tax bracket.

What does it cover?

There are thousands of eligible items, including:

- Copays and coinsurance
- Doctor visits and surgeries
- Over-the-counter medications (first aid, allergy, asthma, cold/flu, heartburn, etc.)
- Prescription drugs
- Birthing and lamaze classes
- Dental and orthodontia
- Frames, contacts, prescription sunglasses, etc.

View our interactive eligible expense list at

www.wexinc.com/insights/benefits-toolkit/eligible-expenses/

Can I enroll?

Yes, as long as you or your spouse aren't actively enrolled and contributing to a health savings account (HSA).



Fast fact

Don't know how much to elect? Determine how much you spent on healthcare expenses last year and estimate the amount you'll spend this year using our eligible expense list. Any funds you contribute to the medical FSA must be spent by the end of the plan year.

> Limited FSA

Why should I choose a limited flexible spending account?

A limited FSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for qualified dental, vision and preventative care expenses. It pairs well with a health Savings Account (HSA). This plan offers instant access to funds for expenses you incur throughout the year. And saves you money by reducing your taxable income.



Funds on Day 1

Buy those eyeglasses or finally get those braces. All of your FSA funds are available to spend right away. Use your benefits debit card at the point of purchase.



Discount

Think of it like a discount on healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens and more. Dollars you contribute are taken out of your paycheck before tax which means a \$100 purchase would actually cost you over \$130 without a limited FSA.*



Plan ahead

Think about the money you spent on healthcare expenses last year. Plan ahead and set those funds aside in a limited FSA and save 30%.*

*Based on a 30% tax bracket.

What does it cover?

There are thousands of eligible items, including:

- Dental and orthodontia office visits and expenses
- Dental implants, dentures and bridges
- Optometrist and ophthalmologist visits and expenses
- Eye glasses, contacts, prescription sunglasses, solutions and drops
- Laser eye surgery

Can I enroll?

The limited FSA pairs nicely with a health savings account (HSA). However, a limited FSA cannot be paired with a medical flexible spending account (FSA). Pairing these plans allows you to spend your limited FSA dollars on eligible expenses while saving or investing your HSA dollars.



Fast fact

Don't know how much to elect? Determine how much you spent on dental and vision expenses last year and estimate the amount you'll spend this year. Any funds you contribute to the limited FSA must be spent by the end of the plan year.

> Dependent Care FSA

Contribution Limits & IRS Regulations

The IRS sets the maximum dollar amount you can elect and contribute to a dependent care flexible spending account (dependent care FSA). The annual contribution limit is:

Per household: \$7,500

Per person (if married and filing separately): \$3,750

Although most people incur more than the limit per year, we recommend reviewing how much you spend on eligible dependent care expenses every year to determine your election.



Funds available as you contribute

Funds will be available to you as they're deducted from your paycheck and contributed to the plan. This means when payroll is processed and your paycheck is available to you, your dependent care FSA contributions will be applied to your account and available for reimbursement.



Use-or-lose

Don't forget to spend your FSA dollars. If you have not used all of your FSA dollars before the end of the plan year, you will forfeit any money left in your account. (Check with your employer to confirm how many days you have to submit claims for reimbursement after the plan year ends.)



Fast Fact

A great way to set it and forget it is to use our Recurring Dependent Care Form that allows you to submit one claim for the entire year and you will be reimbursed after each payroll.

Changing your dependent care FSA election

In order to make changes to your election after open enrollment, you need to experience a qualifying life event. These events include:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status
- Change in daycare providers
- Child turning age 13
- Increase or decrease in the cost of qualifying daycare expenses
- Judgement, decree or order requiring a change in coverage

If you experience a qualifying life event, contact your employer to make changes to your election.

> Dependent Care FSA

Why should I choose a dependent care FSA?

A dependent care FSA allows you to put aside a portion of your paycheck before taxes for eligible dependent care expenses each year.



Save money

The dependent care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You're spending the money either way. This way, eligible childcare and other dependent care costs are a little less.



Save strategically

Submit all of your dependent care expenses at the end of the plan year for one lump sum reimbursement to give yourself a hard-earned "bonus".

Fast Fact

For recurring costs, submit our Recurring Dependent Care Form. It makes claim filing simple because you only need to submit one form once in order to get reimbursed each pay period. You can find the form on the back of this handout.

What does it cover?

The list includes, but is not limited to, eligible:

- Childcare center, babysitter, nanny (birth through age 12)
- Summer day camp
- Before- or after-school care
- Disabled dependent and/or spouse care
- Elder care



DCA Open Enrollment (video)

View our interactive eligible expense list at www.wexinc.com/insights/benefits-toolkit/eligible-expenses/

Can I enroll?

You are eligible if you and/or your spouse (if applicable) are gainfully employed, looking for work, or are attending school on a full-time basis.



Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when you want to receive recurring reimbursement of dependent care expenses. Documentation must be retained for your records and provided to WEX when requested to do so (if a receipt is unavailable, a signature from the provider is sufficient). If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

* = Required Fields

Step 1: Participant Information

	- -
*Participant Name (First, MI, Last)	*Social Security Number
*Employer Name (Do not abbreviate)	Employee ID

Updates or changes to your information can be made by logging into your account at benefitslogin.wexhealth.com.

Step 2: Recurring Dependent Care FSA Information

*Please select only one:

☐ Start Recurring Dependent Care FSA: Please start my recurring reimbursement with the information provided in Step 3.	Effective Date (mm/dd/yyyy)
☐ Change Recurring Dependent Care FSA Information: Please update my recurring reimbursement with the information provided in Step 3 as of the Effective Date listed on the right.	
☐ Stop Recurring Dependent Care FSA: Please stop my recurring reimbursement for the information provided in Step 3 as of the Effective Date listed on the right.	

Step 3: Dependent Care Provider Information and Signature (to be completed by the provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to substantiate the name of the dependent care provider, the dates of service care is being provided and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

*Dependent(s) Name	*Start Date of Service Must be within current plan year (mm/dd/yyyy)	*End Date of Service Must be within current plan year (mm/dd/yyyy)	*Provider's Signature	*Cost Per Week	*Total Cost

Step 4: Participant Certification

To the best of my knowledge, the provided information is complete and accurate. By submitting this, I acknowledge my child is under the age of 13, the services are eligible dependent care expenses as defined by the IRS, that I have not been previously reimbursed for these expenses and that I will not seek reimbursement from any other source. I understand that WEX, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify WEX. I understand that WEX may require me to submit any additional documentation, receipts and an updated request form at any time. I should retain a copy of all submitted documentation in the event of an IRS audit. I confirm my payroll deductions are less than my daycare costs per week so recurring reimbursements will occur when payroll deductions post to my Dependent Care FSA. By submitting this form I certify the above.





Join WellStyles Today!

Earn up to \$200 while improving your health and wellness!

WellStyles is your personalized health and wellness program that's designed to meet you where you're at in your health journey. Our members spend an average of 50 hours per week at work, and we're here to help you carve out time for yourself. Because optimal health is for everyone. **The WellStyles program runs from July 1 - June 30.**

What you can earn:

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	SECRET LEVEL 5
Points	5,000	15,000	35,000	60,000	Unlock to reveal
Rewards	\$20	\$60	\$60	\$60	
Totals	(\$20)	(\$80)	(\$140)	(\$200)	

How to get started:

1

Sign up for your account by going to join.personifyhealth.com/wellstyles

2

Sign up with your information as it appears with your employer

3

Download the Personify Health mobile app for iOS or Android. Access your account and track your activity anywhere, anytime.



Please note: If you create an account through the app, you will need to enter the sponsor name.

Sponsor Name: WellStyles

Who is this for?

WellStyles is for all employees. Once you're signed up, be sure to invite your coworkers to join in on the fun!

Questions?

If you need platform-related assistance, please contact the WellStyles team at info@wellstyles.org.

For password reset or device connection support, please contact Personify Health at support@personifyhealth.com or 1-888-671-9395.



A quick guide to success:

For more information on earning points, visit the Rewards page and click on “How to Earn” for a full list of eligible activities throughout the year. To see what points you have earned to date, go the Rewards page and click on “My Earnings” for a full list.

Activity	Monthly Points Earned
Do one Daily Card = 20 points	
Complete 2 Daily Cards, 5 days a week	200
Bonus: Complete 10 Daily Cards in a month	100
Bonus: Complete 20 Daily Cards in a month	200
Do one Healthy Habit = 10 points	
Track Healthy Habits, 3x a day for 5 days a week	150
Bonus: Track Healthy Habits 10 days in a month	200
Bonus: Track Healthy Habits 20 days in a month	300
Take 7,000 steps in a day = 70 points	
Take 7,000 steps a day for 5 days a week	400
20-Day TT: 7,000 steps/15 active min/15 workout min	400
20-Day TT: 10,000 steps/30 active min/30 workout min	500
Track Sleep Manually per night = 10 points	
Track Sleep Manually 5 days a week	50
Bonus: Track Sleep 10 days in a month	100
Bonus: Track Sleep 20 days in a month	200
Bonus: Sleep > 7 hours 20 days in a month	500
Healthy Habit Challenge = 200 points	
Create a Personal Challenge	50
Virtual WellStyles Events Virtual	
Virtual Events	300

Activity	Yearly Points Earned
Health Assessment	
Find the Health Assessment by clicking on Rewards and scrolling down to the Survey section and click on Health Assessment.	2,500
Preventative Care	
Dental Exam x2	5,000
Vision Exam	2,500
Preventative Vaccine x2	5,000
Cancer Screening x3	15,000
Wellness Exam	20,000
<i>Note: Wellness Exams and Cancer Screenings require documentation. Documentation must include the provider and date of exam/screening. For example, a doctor's note or your explanation of benefits from your medical insurance provider.</i>	
Additional	
WellStyles Annual Survey	1,000
Winter Step Challenge	2,000
Spring Step Challenge	2,000
Additional WellStyles Events x2	600
Health Fair	5000
Deer Valley 5k	5000
Biometric Screening	5000

WellStyles Event points are awarded by Voucher Codes. These 10-digit codes can be applied to your account by clicking on Rewards then by clicking on Redeem a Voucher.



Have questions about the platform?

View our WellStyles Tech-Tip page that has short and sweet tech tip videos designed to help you navigate the WellStyles platform and achieve your health and wellness goals with ease.



Delta Dental PPO™ Summary of Benefits For Group #14267 VSEBG LEVEL II

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

Group Plan Sponsor – VSEBG

Dental Claims Administrator – Delta Dental of Arizona

Benefit Year – January 1 through December 31

Deductible – Delta Dental PPO™ Dentist - \$25 Deductible per person total per Benefit Year limited to a maximum Deductible of \$75 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, X-rays, sealants, periodontal maintenance, and orthodontic services.

Delta Dental Premier® Dentist or Nonparticipating Dentist - \$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, sealants, periodontal maintenance, and orthodontic services.

Benefit Maximum Payment – Delta Dental PPO™ Dentist - \$1,500 per person total per Benefit Year on all services, except oral exams, preventive services, X-rays, sealants, periodontal maintenance, and orthodontic services. \$1,000 per person total per lifetime on orthodontic services.

Delta Dental Premier® Dentist or Nonparticipating Dentist - \$1,000 per person total per Benefit Year on all services, except oral exams, preventive services, X-rays, sealants, periodontal maintenance, and orthodontic services. \$750 per person total per lifetime on orthodontic services.

These are not separate maximums by type of dentist.

Child Age Limit – To age 26

Student Age Limit – To age 26

Covered Services –

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays*	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Sealants – to prevent decay of permanent teeth	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%	70%	70%
Minor Restorative Services – fillings	80%	70%	70%
Endodontic Services – root canals	80%	70%	70%
Periodontic Services – to treat gum disease	80%	70%	70%
Oral Surgery Services – extractions and dental surgery	80%	70%	70%
Other Basic Services – misc. services	80%	70%	70%
Major Services			

Crown Repair – to individual crowns	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Relines and Repairs – to bridges and dentures	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
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.

*Services received from a Delta Dental Premier Dentist are paid based on the Delta Dental PPO Dentist Schedule according to the percentages in this column. This amount may be less than what the dentist would receive based on the Delta Dental Premier Dentist Schedule and you are responsible for that difference. Services received from a Nonparticipating Dentist are paid based on the Delta Dental PPO Dentist Schedule according to the percentages in this column. This amount 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.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- 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 bicuspid and first and second molars for people age 18 and under. The surface must be free from decay and restorations. 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.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are payable.
- 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.
- Silver amalgam and composite resin (white) restorations are payable once per surface in any two-year period.
- Porcelain and resin facings on crowns are optional 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.
- Effective for services rendered 7.1.26 or later - Occlusal guards are payable once in any five-year period.
- Fabrication of athletic mouthguard is payable once in any two-year period for people age 18 and under.

Special Health Care Needs

Members diagnosed with “special health care needs” (as defined below) that significantly impair the Member’s ability to obtain routine covered dental services, may be eligible for additional services, including:

- Additional visits, consultations and/or exams
- Up to four total dental cleanings per benefit year
- Treatment delivery modifications, which may include limited anesthesia, when necessary for dental staff to provide oral health care

“Special health care needs” are any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition requiring medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Special health care needs may include:

- Intellectual and neurodevelopmental disabilities
- Environmental or congenital injuries leading to disability
- Chromosomal abnormalities
- Syndromes or sequences with craniofacial or airway abnormalities
- Other sequences that require special dental care needs
- Any other syndrome, sequence, or abnormality which is not otherwise specified but has a significant deleterious effect in activities of daily living and/or requires significant modification at home and/or in care settings

Special health care needs does not include anxiety, depression, or a fear of dentists or dental treatment (odontophobia).

In evaluating whether you qualify for this special health care needs benefit, your dentist will determine whether they need to change or add new equipment, increase procedure time, and/or change or require additional therapeutic regimes and/or techniques in order to treat you. In making the assessment, your dentist may ask you for documentation evidencing your special health care need. Your dentist will submit the required paperwork to us, and we will determine if you qualify for this benefit. There is no age limit on the special health care need benefit.

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.

Eligible People – As defined by the Employer Group. The Subscriber pays the full cost of this plan.

Enrollees and dependents choosing this Dental Plan are required to remain enrolled for a minimum of 12 months. Should a Subscriber or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Subscriber is enrolled (except under COBRA) and must be enrolled in the same plan as the Subscriber. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

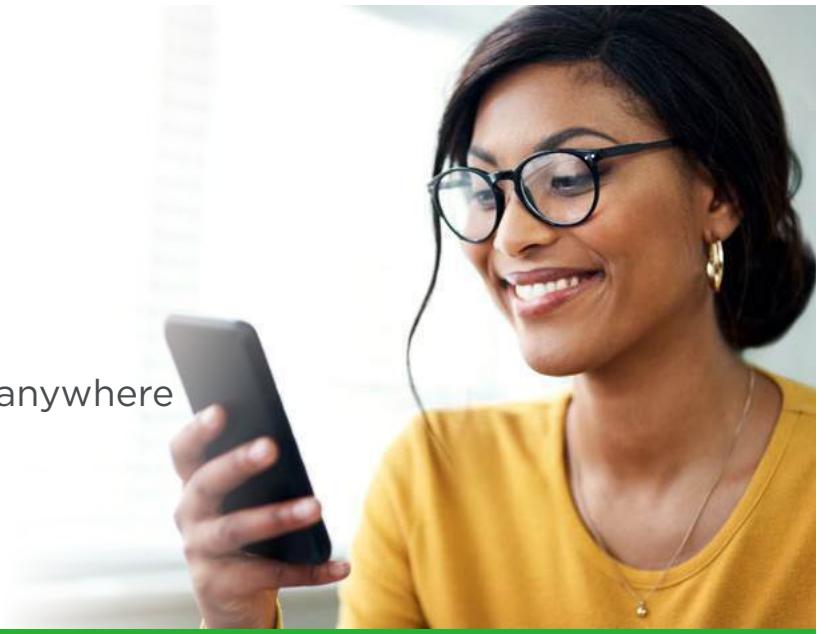
Dual Spouse – If you and your Spouse are both eligible to enroll in this Dental Plan as Subscribers, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate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

Manage your oral health anytime, anywhere



Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, view ID cards and more, right on your mobile device.



Getting started

The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental Mobile App. Or, scan the QR code below. You will need an internet connection in order to download and use most features of our free app.

Logging in to view benefits

Delta Dental members can sign in using the username and password they use to sign in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental Mobile App.



SCAN TO DOWNLOAD
DELTA DENTAL MOBILE APP

Delta Dental Mobile App features

Sign in to access the full range of tools and resources



Mobile ID card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.



Find a dentist

It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.



Dental Care Cost Estimator

Find out what to expect with our Dental Care Cost Estimator. Our easy to use tool provides estimated cost ranges on common dental care needs for dentists in your area, now with the option to select your dentist for tailored cost estimates.



Save your preferred dentist for quick access

Save your favorite dentists using the Delta Dental Mobile App for quick access to contact information making it easy to schedule your routine cleaning.



My claims

Look up detailed claims information for your dentist visits over the last 18 months.

Secure access to your benefits

You must sign in each time you access the secure portion of the mobile app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed by clicking the lock icon on the main menu.

Please note information displayed may vary based on your particular coverage. For more information on your coverage, contact your Delta Dental company. "Delta Dental" refers to the national network of 39 independent Delta Dental companies that provide dental benefits and is a registered trademark of Delta Dental Plans Association.

deltadentalaz.com

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Arizona Dental Insurance Service, Inc. dba Delta Dental of Arizona. DDPA-0009-rev0622





CheckUp Plus™

Good oral health is essential to overall wellness. Regular visits to the dentist help prevent tooth decay and detect early signs of disease. That's why Delta Dental of Arizona offers members CheckUp Plus.

With the CheckUp Plus program, preventive and diagnostic services, like cleanings, exams and X-rays, are not deducted from your annual maximum—giving you more money to use when you need it most.

CheckUp Plus:

- Encourages you to visit the dentist for routine cleanings, exams and X-rays—which can improve your overall health
- Preserves your annual maximum dollars for more serious or costly dental services
- Saves you money in the long-term because preventive care can help reduce the need for more expensive dental treatment

Example of savings from CheckUp Plus

Annual Preventive Services	You Pay	Delta Dental Pays	Annual Maximum Remaining WITHOUT CheckUp Plus	Annual Maximum Remaining WITH CheckUp Plus
2 cleanings	\$0	\$140	\$1,860	\$2,000
2 exams	\$0	\$82	\$1,918	\$2,000
1 set of X-rays	\$0	\$92	\$1,908	\$2,000
Total	\$0	\$314	\$1,686	\$2,000

With CheckUp Plus, you have \$314 more to use toward restorative dental care!

Chart above is for illustrative purposes only. Assumes services are provided by Delta Dental network dentists. Actual savings may vary.





CheckUp Plus™

La buena salud oral es esencial para el bienestar general. Las visitas regulares al dentista ayudan a prevenir la caries dental y a detectar los signos tempranos de enfermedad. Por esa razón Delta Dental de Arizona les ofrece a los miembros el programa de Checkup Plus.

Con el programa CheckUp Plus, los servicios preventivos y de diagnóstico, como limpiezas, exámenes y rayos X, no se deducen de su máximo anual – lo cual resulta en más dinero para usar cuando más lo necesita.

El Programa de CheckUp Plus:

- Promueve las visitas rutinarias al dentista para las limpiezas, exámenes y radiografías, lo que puede mejorar su salud general
- Conserva sus dólares anuales máximos para servicios dentales más serios o costoso
- Le ahorra dinero a largo plazo porque la atención preventiva puede ayudar a reducir la necesidad de un tratamiento dental más caro

Ejemplo de los ahorros con CheckUp Plus

Servicios Preventivos Anuales	Usted Paga	Delta Dental Paga	Máximo Anual Restante SIN CheckUp Plus	Máximo Anual Restante CON CheckUp Plus
2 limpiezas	\$0	\$140	\$1,860	\$2,000
2 exámenes	\$0	\$82	\$1,918	\$2,000
1 conjunto de rayos X	\$0	\$92	\$1,908	\$2,000
Total	\$0	\$314	\$1,686	\$2,000

Con CheckUp Plus, usted tiene \$314 dólares más para usar en el cuidado dental restaurativo

El gráfico anterior es sólo para fines ilustrativos y supone que los servicios son proporcionados por dentistas participantes en la red de Delta Dental. Los ahorros reales pueden variar.





Third Cleaning Benefit

Wouldn't it be nice if you needed extra care and could have it covered by your dental plan? With Delta Dental of Arizona, you can.

Delta Dental's Evidence-based Dentistry (EBD) plan benefit provides a third cleaning for individuals with certain medical conditions that have oral health implications.¹ Research has shown that increased frequency of cleanings can greatly impact oral health and sometimes even play an important role in managing conditions, such as:



Diabetes



Pregnancy



Heart disease and defects



Head and neck radiation



Renal failure or dialysis



Rheumatoid arthritis



Cancer



Suppressed immune systems
(due to chemotherapy/radiation, HIV positive, organ transplant or stem cell/bone marrow transplant)



Periodontal Disease

How to Register

Qualifying members must enroll for the enhanced preventive benefits to receive coverage for a third dental cleaning. To enroll, please call our customer service team at 800.352.6132.



deltadentalaz.com

¹Enrolled members receive a third dental cleaning per benefit year. Please check your plan documentation for specific plan benefits and limitations.
Arizona Dental Insurance Service, Inc. dba Delta Dental of Arizona. DDAZ-0076-rev0722



El beneficio de una tercera limpieza

¿No sería bueno si usted necesitara atención dental adicional y esta pudiera ser cubierta por su plan de seguro? Con Delta Dental de Arizona, es posible.

El beneficio del plan de odontología basada en la evidencia (en inglés, EBD) de Delta Dental ofrece una tercera limpieza para personas con ciertas condiciones médicas que tienen implicaciones para la salud bucal¹. Las investigaciones han demostrado que el aumento de la frecuencia de las limpiezas puede impactar considerablemente la salud bucal y a veces incluso desempeñar un papel importante en el manejo de condiciones tales como:



Diabetes



Embarazo



Enfermedad y defectos del corazón



Radioterapia de cabeza y cuello



Insuficiencia renal o diálisis



Artritis reumatoide



Cáncer



Sistemas inmunes suprimidos
(debido a la quimioterapia/radiación, VIH positivo,
trasplante de órgano o de células madre/médula ósea)



Enfermedad periodontal

Cómo inscribirse

Los miembros que califiquen necesitan inscribirse para los beneficios preventivos aumentados para recibir cobertura para una tercera limpieza dental. Para inscribirse, por favor llame a nuestro equipo de atención al cliente al 800.352.6132.



deltadentalaz.com



Valley Schools Dental Benefit Option

A Guide to your Cigna Dental Care® (DHMO) Plan

Sponsored by Valley Schools | 2026



For employees of
Valley Schools
and their covered
dependents.



Offered by Cigna Health and
Life Insurance Company, or its affiliates



Important plan information

We are pleased to provide information about the Cigna Dental Care® (DHMO) plan. This plan offers a full range of benefits through a network of plan dentists.

Important details

During open enrollment, you will need to select a Cigna Dental Care Access Network General Dentist. If you or covered family members would like to change your general dentist, you can do so following the instructions in this brochure. For children under the age of 13 you may choose a network pediatric dentist. If you need assistance in changing your dentist, contact Cigna Healthcare® at **800.Cigna24**.

- You will pay the copay amount listed on your Patient Charge Schedule (PCS) for covered dental services performed by your network dentist.
- If your Network General Dentist does not perform the specialty care procedure you need, he/she can direct you to a participating network specialist.
- Procedures not listed on your PCS are not covered and are the patient's responsibility at the dentist's usual fees.
- Referrals are required for specialty care services, except for pediatric dentists for children under 13 and orthodontics.
- Remember: If you seek covered services from a dentist who does not participate in the Cigna Dental Care Access network, your plan will not pay except in the case of an emergency, or as required by law.

What's covered

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing x-rays, full-mouth x-rays and more.
- **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam).
- **Major services** – crowns, bridges, dentures, root canals, oral surgery, extractions, treatment for periodontal (gum) disease and more.
- **Specialty care** – referrals are required for specialty care, except for pediatric dentists for children under 13 and orthodontics.
- **Orthodontic care** – coverage for braces for children and adults.
- **General anesthesia** – when medically necessary.
- **Temporomandibular joint (TMJ)** – diagnosis and treatment procedures, including cone beam x-ray and appliance.



Plan features:

- **No deductibles** – you don't have to reach a certain level of out-of-pocket expenses before your coverage kicks in.
- **No calendar year maximums** – your coverage isn't limited by a calendar year maximum.
- There are **no claim forms** to file when using network dentists and **no waiting periods** for coverage.
- Coverage for dental conditions that exist at the time you enroll in the plan are not excluded if they are otherwise covered under your PCS. Treatment started before your coverage begins will generally not be covered. If you or a family member started orthodontic treatment before you joined the Cigna Dental Care plan, your plan may help pay for covered costs. See page 6 for more information.



Your Questions Answered

Q: How does the Cigna Dental Care (DHMO) Plan work?

A: When you enroll in the Cigna Dental Care (DHMO) plan, you will be able to select a Cigna Dental Care Access Network General Dentist during open enrollment. You then receive a Patient Charge Schedule, or PCS, that lists the specific dental procedures covered by the plan and the amount you will pay the dentist (your copays). These copays apply only when you receive treatment from the dentists or dental specialists in our Cigna Dental Care Access network.

If a dental procedure is not listed on your PCS, it is not covered and you will have to pay according to the dentist's regular fees. If you receive a covered service from a dentist who does not participate in the Cigna Dental Care Access network, your dental benefits may not be covered at all. You can take your PCS to dental appointments to discuss treatment options and costs with your dentist (but it is not required).

Q: How do I change my Network General Dentist?

A: You can find a Cigna Dental Care Access network dentist by visiting **Cigna.com**® or go to your personalized website at **myCigna.com**® after you sign up. If you need help finding a dentist, you can call the customer service number below and request to have a list of providers mailed, emailed or faxed to you. You can change your network dentist at any time; changes made by the 15th of the month will go into effect the first of the following month. Remember, if you visit a non-network dentist, your treatment may not be covered at all.

If you'd like to speak with someone, call customer service at **800.Cigna24**. You can also follow the phone prompts to use our automated Dental Office Locator. The automated system will speak the names of the dentists in your area, mail, email or fax a list of dentists to you.

Q: If I'm new to the Cigna Dental Care Plan, can I keep my current dentist?

A: That depends. If your current dentist participates in the Cigna Dental Care Access network, you can choose him/her as your Network General Dentist. You can look online at **Cigna.com** to find out, or ask your dental office directly. Sometimes, Cigna Healthcare's online Dental Office Directory may show that your dental office is not accepting new patients. If this happens, please contact customer service at **800.Cigna24** for assistance.

Q: Do I need a referral to visit a dental specialist?

A: Yes. If you require specialty care, your Network General Dentist will refer you to a network dental specialist – and handle any paperwork. Referrals are required for all network specialists, except orthodontists and pediatric dentists.

Q: Do I need to show my ID card when I arrive at the dentist's office?

A: No. ID cards are not required to use the plan. When you call to schedule your appointment, just let your selected Cigna Dental Care Access network dental office know that you are covered under the Cigna Dental Care Plan. If for some reason the dental office does not see your name on its list of Cigna Dental Care customers, they can call us to verify. You can also call customer service at **800.Cigna24** if you need more help.

Q: When do I have to pay the dentist?

A: That depends on the financial arrangement between you and your network dentist. We encourage you to discuss costs and payment arrangements for dental treatment with your dentist before you receive care. Most dentists will work with their patients to arrange payment plans for more costly treatments.

Q: Do I have to submit a claim to Cigna Healthcare after I receive treatment?

A: No. Your network dentist will do that for you. The only exceptions are emergency care received out of your service area. For details, please refer to the section concerning emergency care.

Q: Are braces covered?

A: Yes. A lifetime maximum benefit of 24 months of interceptive and/or comprehensive orthodontic treatment is covered as shown in the PCS. Cases beyond 24 months may require additional payments by the patient, which are based on the dentist's contracted fee and may be different from the copay listed in the PCS. If you or your family member started

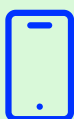
treatment before you joined the Cigna Dental Care plan (called “orthodontics in progress”), your new coverage may help pay some of your orthodontic costs. After you enroll, your orthodontist can complete a standard Orthodontics in Progress form or you can get one by calling Cigna Healthcare customer service at **800.Cigna24**. To complete the form, you must know the phase of treatment and the number of months of treatment you have left when your new Cigna Healthcare plan starts.

Q: What if I have a dental emergency and can't get treatment from my Cigna Dental Care Access network dentist?

A: Emergency services: If you are out of your service area or unable to contact your Network General Dentist, you may receive emergency services by any licensed dentist for unexpected but necessary services. Emergency services are limited to relieving severe pain, controlling excessive bleeding and eliminating serious and sudden (“acute”) infection. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care and you should return to your Network General Dentist for these procedures.

Emergency care out of your service area: For emergency covered services, you will be responsible for the Patient Charges listed on your PCS. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency covered services and your Patient Charge, up to a total of \$50 per incident (this amount may vary by state). To request reimbursement, send the dentist's itemized statement to Cigna Dental at the address listed for your state on your plan materials.

Emergency care after hours: There is a copay listed on your PCS for emergency care received after regularly scheduled office hours. This copay will be in addition to other copays that may apply.



Virtual Dental Care*

Talk to a dentist 24/7. If you are unable to reach your regular provider, you have the option to consult with a network general dentist on **myCigna.com**

Virtual Care treatment includes:

- Dental pain
- Oral sores, swelling
- Sensitive teeth
- Medication management or infections.



How to find a dentist

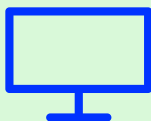
It's easy to find a Cigna Dental Care Access network dentist or specialist.

Before you enroll, you can check to see if your dentist is in the Cigna Dental Care Access network. Here's how.

Visit Cigna.com

- To search for a dentist on **Cigna.com**, visit the site and click “**Find a Doctor, Dentist or Facility.**”
- Under “How are you covered” click “Employer or school”
- Follow the prompts on screen and when asked to choose your plan, select “CIGNA DENTAL CARE DHMO > Cigna Dental Care Access.
- Review the lists given by specialty. Or narrow your search by typing in provider name, specialty or office name.
- Once you get your search results, you can further refine your search by:
 - Distance
 - Years in practice
 - Specialty
 - Additional languages
- Click on a dentist's name for more details. Such as office hours and location listings with map view.





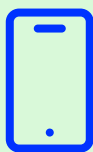
Once you're enrolled, register for myCigna.com² to find a Cigna Dental Care Access network dentist, compare the cost of procedures and so much more.

It's easy to set up.

Visit **myCigna.com** or the myCigna® App today:³

- **Select** "Register"
- **Enter** your name, address and date of birth
- **Confirm** your identity with your Cigna Healthcare ID number, Social Security number, or with the myCigna security questionnaire
- **Create** a user ID and password
- **Review** then select "Submit"

Already have an ID but haven't visited in a while? That's ok! If you don't remember your ID or password, just click "forgot user ID" or "forgot password" on the registration page and we'll help you out.



You can also find a network dentist 24/7/365 by calling the number on your ID card, or 800.Cigna24.

- Use the Dental Office Locator via Speech Recognition.
- Speak with a customer service representative, who can send you a customized network directory listing via email.
- Ask coworkers. Then tell us which office you choose. Each covered family member can select his/her own Cigna Dental Care Access Network General Dentist.

Under your plan, you have coverage for **hundreds** of dental procedures. This overview shows you a small sampling of covered services and what you will pay compared to your estimated **cost without coverage**. See savings below.

You can find a full list of dental procedures on the PCS available from your employer.

Sampling of covered procedures	What you'll pay ⁴	
	Cost with Cigna Dental Care	Estimated cost without dental coverage
	General Dentist	
Adult cleaning (two per calendar year, additional cleaning \$45)	\$0	\$74–\$160 each
Child cleaning (two per calendar year, additional cleaning \$30)	\$0	\$57–\$123 each
Periodic oral evaluation	\$0	\$43–\$93
Comprehensive oral evaluation	\$0	\$68–\$147
Topical fluoride (two per calendar year)	\$0	\$30–\$65
X-rays – (bitewings) 4 radiographic images	\$0	\$51–\$111
X-rays – panoramic film (one every three years)	\$0	\$89–\$193
Sealant – per tooth	\$17	\$45–\$96
Amalgam filling (silver colored) – 2 surfaces	\$22	\$106–\$229
Composite filling (tooth-colored) – 1 surface, Anterior	\$22	\$127–\$275
Molar root canal (excluding final restoration)	\$530	\$896–\$1,939
Periodontal (gum) scaling and root planing – 1–3 teeth per quadrant	\$64	\$149–\$322
Periodontal (gum) maintenance	\$78	\$114–\$246
Removal/extraction of erupted tooth	\$53	\$134–\$291
Removal/extraction of impacted tooth – soft tissue	\$125	\$268–\$580
Crown – porcelain fused to high noble metal	\$470	\$886–\$1,918
External bleaching for home application, per arch; includes materials and fabrication of custom trays	\$165	\$110–\$237
Occlusal orthotic device, by report (for treatment of TMJ)	\$455	\$730–\$1,580

Chart is for illustrative purposes only.

Summary of Limitations

Procedure	Limit
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorax1 every 3 calendar years
Periodontal root planning and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (only covered after active periodontal therapy)
Crowns, dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	If covered, maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months may require an additional payment by the patient
Relines	One every 36 months
Denture adjustments	Four within the first 6 months after installation
Prosthesis over implant	If covered, replacement limited to once every 5 years if unserviceable and cannot be repaired
Surgical placement of implant	If covered, surgical placement of implants (D6010, D6012, D6040, and D6050) have a limit of 1 implant per calendar year with a replacement of 1 per 10 years
Temporomandibular Joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/ IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule (PCS). IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.
Fluoride treatments	Two treatments per year covered at 100%

Specialty treatment plans may require payment authorization for services to be covered. Before treatment starts, you should verify with your network specialty dentist that your treatment plan has been authorized for payment by Cigna Healthcare. Depending on your plan, if more than one professionally accepted and appropriate method of treatment can be used to treat a dental condition, coverage may be limited to the less costly covered service. If you choose the more costly service, the fee listed on the Patient Charge Schedule may not apply. Review your plan documents for the details of your employer’s specific dental plan.

EXCLUSIONS: Listed below are the services or expenses which are NOT covered under your Dental Plan. You will be responsible for these services at the dentist's usual fees.

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- Services received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- Services for the charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Services received due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)⁵
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of wars⁶
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- Prescription medications

- Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen or damaged due to patient abuse, misuse or neglect
- Surgical implant of any type unless specifically listed on your PCS
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- Services to the extent you or your enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy⁷
- The completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage⁸
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental Coverage, unless specifically listed on your PCS⁸
- Consultations and/or evaluations associated with services that are not covered
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy

- Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

This document outlines the highlights of your plan. For a complete list of both covered and non-covered services, including benefits required by your state, see your insurance certificate or plan description. If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.





How to enroll and how to change your general dentist

Enroll today

Make sure that you don't miss your opportunity to enroll for this important benefit. All you need to do is:

1. Review your plan materials and consider your family's needs.
2. Contact your Human Resources benefits coordinator for enrollment instructions.
3. Select your Network General Dentist. If you wish to change your dentist, you can do so by following the instructions below.

Change your Network General Dentist

1. The list of Cigna Dental Care Access network dentists is available at **Cigna.com**, via our mobile app or by calling customer service at **800.Cigna24**. To receive the most benefits from the Cigna Dental Care Plan you must select and use a Cigna Dental Care Access Network General Dentist.
2. Contact your Human Resources Benefits department.





Need more? Get more

Cigna Dental Oral Health Integration Program[®]

What is the Cigna Dental Oral Health Integration Program⁹?

It's a program that reimburses out-of-pocket costs for specific dental services used to treat or help prevent gum disease and tooth decay. The program is for people with certain medical conditions that have been found to be associated with gum disease. There's no additional cost for the program – if you qualify, you get reimbursed!

Do I qualify?

If you have a Cigna dental plan, you're eligible for the program. You do NOT have to be enrolled in a Cigna Healthcare medical plan to be eligible for this program. You must currently be under treatment by a doctor for any of the following conditions:

- Rheumatoid Arthritis
- Heart disease
- Stroke
- Diabetes
- Head and neck cancer radiation
- Maternity
- Chronic kidney disease
- Organ transplants
- Sjogren's Syndrome
- Lupus
- Parkinson's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- Huntington's Disease
- Opioid Misuse and Addiction

Using the program is as easy as 1, 2, 3!

Together, we can make sure proper dental care is given to those who need it most.

- 1 You must fill out the online registration form found on myCigna.com. You can also call the number on the back of your ID card to have an enrollment form sent to you. You only need to complete the form one time per qualifying condition, except for maternity.
- 2 Once you're logged in on myCigna.com, click "Review my Coverage" then select "Dental" from the drop down menu. Next, from the "Related Links" section on the right side of the page, select "Cigna Dental Oral Health Integration Program Registration Form." Fill out the form and click "Submit".

- 3 Visit your dentist and pay your usual out-of-pocket cost for the covered service. We'll send your reimbursement.

How does it work?

When you visit your dentist, you will pay your usual out-of-pocket costs (deductible, copay or coinsurance amount). As a reminder, your copay is the fixed amount you pay for covered services, and your coinsurance is the percentage of costs you pay for covered services. Next, your dentist will send Cigna Healthcare a claim. We review the claim and will refund your out-of-pocket costs for eligible dental services. Once we receive your claim, you can expect to be reimbursed in about 30 days. You must enroll in this program prior to receiving treatment to be eligible for reimbursement.



Healthy Rewards

As a Cigna Healthcare member, you have access to discounts on the health products and programs you use every day for:**

- Nutritional Meal Delivery Service
- Fitness Memberships and Devices***
- Vision Care, Lasik Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts***

Real brands. Real discounts. Real easy.

Log into **myCigna.com** and navigate to Healthy Rewards Discount Program or call **800.870.3470**.

Get Valley Schools Cigna Dental (DHMO) Plan electronic guide.

The guide can help:

- Explain how the plan works
- Explore the plan network
- View patient charge schedule
- Learn about the Oral Health Integration Program
- View the Valley Schools plan brochure



Visit <http://view.ceros.com/cigna/valley-schools/p/1> or scan the QR code for access.



*Cigna Healthcare provides access to virtual care through national teledental care providers via myCigna.com as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers and is a requirement for this service. See your plan materials for the details of your specific Dental plan. This service is separate from coverage for virtual dental care obtained by your Dental plan's network and may not be available in all areas. A referral is not required for this service.

**Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your health plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge. All goods, services and discounts offered through Healthy Rewards are provided by third parties who are solely responsible for their products, services and discounts.

***Fitness Membership and Devices along with Yoga Products and Virtual Workouts can only be accessed by login into myCigna.com and navigating to Healthy Rewards Discount Program.

1. The term "DHMO" refers to group dental products that may differ by the state an enrollee lives in. This can include prepaid plans, managed care plans, and plans with open access features. The Cigna Dental Care (DHMO) plan is not available in all states.
2. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
3. App/online store terms and mobile phone carrier/data charges apply.
4. Charges are based on 2019 claim data and projected for 2020 and is subject to change. The Ignition Group makes no warranty regarding the performance of the data and the results that will be obtained by using. These are examples used for illustrative purposes only. Your actual costs and plan coverage will vary. Plan limitations and exclusions may apply. See your plan materials for details.
5. A benefit is paid for covered out-of-network emergency dental care. Certain states mandate coverage for dental care received out-of-network. For example, in Minnesota, the plan will pay 50% of the value of your network benefit for covered out-of-network services. In Oklahoma, the plan will pay the same amount it pays network dentists for covered out-of-network services. You are responsible for any charges not covered by the plan. Other states may have similar mandates. Refer to your plan documents for cost and coverage details.
6. **Oklahoma residents:** This exclusion is replaced by the following: War or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
7. **Arizona and Pennsylvania residents:** This exclusion does not apply. **Kentucky and North Carolina residents:** Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. **Maryland residents:** Services compensated under group medical plans are not excluded.
8. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under your PCS.
9. This program provides reimbursement for certain eligible dental procedures for customers with qualifying medical conditions. Customers must enroll in the program prior to receiving dental services to be eligible for reimbursement. Reimbursement is applied to and subject to any applicable annual benefits maximum. See your plan documents or contact Cigna Healthcare for complete program details.

Product availability may vary by location and plan type and is subject to change. All group dental plans and insurance policies have exclusions and limitations. For costs and complete details of coverage, see your plan documents. The dentists who participate in Cigna Healthcare's network are independent contractors solely responsible for the treatment provided to their patients. Dentists are not agents of Cigna Healthcare.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (CHLIC), or their affiliates, and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc. including Cigna Dental Health Plan of Arizona, Inc., Policy forms: OK – HP-APP-1 et al., OR – HP-POL38 02-13, TN – HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

Cigna Dental Care[®] Plan Patient Charge Schedule

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested that you check with your Network Dentist in advance of receiving services.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made by your Network General Dentist to a Network Specialty Endodontist, Periodontist or Oral Surgeon. A referral is not required for Specialty Care at a Network Specialty Pediatric Dentist



or Orthodontist. You may select a Network Pediatric Dentist for your child under the age of 13 by calling Customer Service at 1.800.Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 13th birthday.

- Procedures not listed on this Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- Infection control and/or sterilization are considered to be incidental to and part of the charges for services provided and not separately chargeable.
- This Patient Charge Schedule is subject to *annual change* in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract. However, additional benefits may be available in certain states (e.g. Arizona), for Covered Services otherwise subject to a frequency limitation, dependent upon your Network General Dentist's certification of dental necessity. Should any applicable state regulation require coverage for a particular service, the listed exclusion or limitation for that service shall not apply.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the *procedure is initiated*.
- Current Dental Terminology ("CDT") codes are established by the American Dental Association (ADA) Council on Dental Benefit Programs in accordance with authority granted by the federal government under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) as the national terminology for reporting dental services, and are recognized as the industry standard. The ADA publishes CDT as part of a reference manual and may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures. The language in *italics* is intended to clarify the members' benefit.

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
Office visit fee (Per patient, per office visit in addition to any other applicable patient charges)		
	Office visit fee	\$0.00
Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180) and oral evaluations for patients under 3 years of age (D0145).		
D9310	Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)	\$0.00
D9311	Consultation with a medical health care professional	\$0.00
D9430	Office visit for observation – No other services performed	\$0.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	\$0.00
D0120	Periodic oral evaluation – Established patient	\$0.00
D0140	Limited oral evaluation – Problem focused	\$0.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	\$0.00
D0150	Comprehensive oral evaluation – New or established patient	\$0.00
D0160	Detailed and extensive oral evaluation - Problem focused, by report (<i>limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation</i>)	\$0.00
D0170	Re-evaluation – Limited, problem focused (established patient; not post-operative visit)	\$0.00
D0171	Re-evaluation – Post-operative office visit	\$0.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D0180	Comprehensive periodontal evaluation – New or established patient	\$43.00
D0210	X-rays intraoral – Comprehensive series of radiographic images <i>(limited to 1 D0210 or D0709 every 3 years)</i>	\$0.00
D0220	X-rays intraoral – Periapical – First radiographic image	\$0.00
D0230	X-rays intraoral – Periapical – Each additional radiographic image	\$0.00
D0240	X-rays intraoral – Occlusal radiographic image	\$0.00
D0250	X-rays extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	\$0.00
D0251	X-rays extra-oral posterior dental radiographic image <i>(limit 1 D0251 or D0705 per calendar year)</i>	\$0.00
D0270	X-rays (bitewing) – Single radiographic image	\$0.00
D0272	X-rays (bitewings) – 2 radiographic images	\$0.00
D0273	X-rays (bitewings) – 3 radiographic images	\$0.00
D0274	X-rays (bitewings) – 4 radiographic images	\$0.00
D0277	X-rays (bitewings, vertical) – 7 to 8 radiographic images	\$0.00
D0330	X-rays (panoramic radiographic image) – <i>(limited to 1 D0330 or D0701 every 3 years) (when utilized for orthodontic services, see D8999)</i>	\$0.00
D0340	2D cephalometric radiographic image - Acquisition, measurement and analysis <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00
D0350	2D oral/facial photographic images obtained intra-orally or extra-orally <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures (<i>limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation</i>)	\$240.00
D0372	Intraoral tomosynthesis – Comprehensive series of radiographic images	\$0.00
D0373	Intraoral tomosynthesis – Bitewing radiographic image	\$0.00
D0374	Intraoral tomosynthesis – Periapical radiographic image	\$0.00
D0387	Intraoral tomosynthesis – Comprehensive series of radiographic images – Image capture only	\$0.00
D0388	Intraoral tomosynthesis – Bitewing radiographic image – Image capture only	\$0.00
D0389	Intraoral tomosynthesis – Periapical radiographic image – Image capture only	\$0.00
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	\$0.00
D0393	Virtual treatment simulation using 3D image volume or surface scan	\$0.00
D0394	Digital subtraction of two or more images or image volumes of the same modality	\$0.00
D0395	Fusion of two or more 3D image volumes of one or more modalities	\$0.00
D0396	3D printing of a 3D dental surface scan	\$0.00
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation, and transmission of written report	\$0.00
D0431	Oral cancer screening using a special light source	\$50.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D0460	Pulp vitality tests	\$14.00
D0470	Diagnostic casts <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00
D0472	Pathology report – Gross examination of lesion (only when tooth related)	\$0.00
D0473	Pathology report – Microscopic examination of lesion (only when tooth related)	\$0.00
D0474	Pathology report – Microscopic examination of lesion and area (only when tooth related)	\$0.00
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum	\$0.00
D0701	X-rays (panoramic radiographic image) – Image capture only <i>(limited to 1 D0330 or D0701 every 3 years) (when utilized for orthodontic services, see D8999)</i>	\$0.00
D0702	2D cephalometric radiographic image – Image capture only <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally – Image capture only <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00
D0705	X-rays extra-oral posterior dental radiographic image – Image capture only <i>(limited to 1 D0251 or D0705 per calendar year)</i>	\$0.00
D0706	X-rays intraoral – Occlusal radiographic image – Image capture only	\$0.00
D0707	X-rays intraoral – Periapical radiographic image – Image capture only	\$0.00
D0708	X-rays intraoral – Bitewing radiographic image – Image capture only	\$0.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D0709	X-rays intraoral – Comprehensive series of radiographic images – Image capture only <i>(limit 1 D0210 or D0709 every 3 years)</i>	\$0.00
D0801	3D dental surface scan – Direct <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00
D0802	3D dental surface scan – Indirect <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00
D0803	3D facial surface scan – Direct <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00
D0804	3D facial surface scan – Indirect <i>(when utilized for orthodontic services, see D8999)</i>	\$0.00
D1110	Prophylaxis (cleaning) – Adult <i>(limit 2 per calendar year)</i>	\$0.00
	Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	\$45.00
D1120	Prophylaxis (cleaning) – Child <i>(limit 2 per calendar year)</i>	\$0.00
	Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	\$30.00
D1206	Topical application of fluoride varnish <i>(limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/ or D1208s per calendar year.</i>	\$0.00
	Additional topical application of fluoride varnish in addition to any combination of two (2) D1206s (topical application of fluoride varnish) and/or D1208s (topical application of fluoride - excluding varnish) per calendar year	\$15.00
D1208	Topical application of fluoride - Excluding varnish <i>(limit 2 per calendar year) There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.</i>	\$0.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
	Additional topical application of fluoride - Excluding varnish - In addition to any combination of two (2) D1206s (topical applications of fluoride varnish) and/or D1208s (topical application of fluoride - excluding varnish) per calendar year	\$15.00
D1310	Nutritional counseling for control of dental disease	\$0.00
D1330	Oral hygiene instructions	\$0.00
D1351	Sealant – Per tooth	\$17.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	\$17.00
D1353	Sealant repair – Per tooth	\$11.00
D1354	Application of caries arresting medicament - Per tooth	\$0.00
D1355	Caries preventive medicament application – Per tooth	\$0.00
D1510	Space maintainer – Fixed - Unilateral - Per quadrant	\$110.00
D1516	Space maintainer – Fixed – Bilateral, upper	\$170.00
D1517	Space maintainer – Fixed – Bilateral, lower	\$170.00
D1520	Space maintainer – Removable - Unilateral - Per quadrant	\$110.00
D1526	Space maintainer – Removable – Bilateral, upper	\$170.00
D1527	Space maintainer – Removable – Bilateral, lower	\$170.00
D1551	Re-cement or re-bond bilateral space maintainer – Upper	\$0.00
D1552	Re-cement or re-bond bilateral space maintainer – Lower	\$0.00
D1553	Re-cement or re-bond unilateral space maintainer – Per quadrant	\$0.00
D1556	Removal of fixed unilateral space maintainer – Per quadrant	\$0.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D1557	Removal of fixed bilateral space maintainer – Upper	\$0.00
D1558	Removal of fixed bilateral space maintainer – Lower	\$0.00
D1575	Distal shoe space maintainer – Fixed, Unilateral - Per quadrant	\$121.00
Restorative (fillings - primary or permanent teeth, including polishing)		
D2140	Amalgam – 1 surface, primary or permanent	\$17.00
D2150	Amalgam – 2 surfaces, primary or permanent	\$22.00
D2160	Amalgam – 3 surfaces, primary or permanent	\$28.00
D2161	Amalgam – 4 or more surfaces, primary or permanent	\$35.00
D2330	Resin-based composite – 1 surface, anterior	\$22.00
D2331	Resin-based composite – 2 surfaces, anterior	\$29.00
D2332	Resin-based composite – 3 surfaces, anterior	\$35.00
D2335	Resin-based composite – 4 or more surfaces, anterior	\$88.00
D2390	Resin-based composite crown, anterior	\$115.00
D2391	Resin-based composite – 1 surface, posterior	\$47.00
D2392	Resin-based composite – 2 surfaces, posterior	\$59.00
D2393	Resin-based composite – 3 surfaces, posterior	\$82.00
D2394	Resin-based composite – 4 or more surfaces, posterior	\$115.00
Crown and bridge – All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals 1 unit). Coverage for replacement of crowns and bridges is limited to 1 every 5 years. If your dentist offers same day in-office CAD/CAM (ceramic) services, they may charge an additional fee of no more than \$150.00 per tooth/unit for crowns, bridges, inlays, onlays, post and cores, and veneers. Same day in-office CAD/CAM (ceramic) services refer to dental restorations that are created and		

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
delivered in the dental office the same day using a digital impression and an in-office CAD/CAM milling machine.		
D2510	Inlay – Metallic – 1 surface	\$430.00
D2520	Inlay – Metallic – 2 surfaces	\$430.00
D2530	Inlay – Metallic – 3 or more surfaces	\$430.00
D2542	Onlay – Metallic – 2 surfaces	\$490.00
D2543	Onlay – Metallic – 3 surfaces	\$490.00
D2544	Onlay – Metallic – 4 or more surfaces	\$490.00
D2710	Crown – Resin-based composite, indirect	\$260.00
D2712	Crown – 3/4 resin-based composite, indirect	\$370.00
D2720	Crown – Resin with high noble metal	\$380.00
D2721	Crown – Resin with predominantly base metal	\$335.00
D2722	Crown – Resin with noble metal	\$355.00
D2740	Crown – Porcelain/ceramic	\$515.00
D2750	Crown – Porcelain fused to high noble metal	\$470.00
D2751	Crown – Porcelain fused to predominantly base metal	\$415.00
D2752	Crown – Porcelain fused to noble metal	\$440.00
D2753	Crown – Porcelain fused to titanium and titanium alloys	\$470.00
D2780	Crown – 3/4 cast high noble metal	\$480.00
D2781	Crown – 3/4 cast predominantly base metal	\$425.00
D2782	Crown – 3/4 cast noble metal	\$450.00
D2783	Crown – 3/4 porcelain/ceramic	\$515.00
D2790	Crown – Full cast high noble metal	\$480.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D2791	Crown – Full cast predominantly base metal	\$425.00
D2792	Crown – Full cast noble metal	\$450.00
D2794	Crown – Titanium and titanium alloys	\$480.00
D2799	Interim crown (<i>not to be used as a temporary crown for a routine prosthetic restoration</i>)	\$135.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$43.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$43.00
D2920	Re-cement or re-bond crown	\$43.00
D2928	Prefabricated porcelain/ceramic crown – Permanent tooth	\$155.00
D2929	Prefabricated porcelain/ceramic crown - Primary tooth	\$155.00
D2930	Prefabricated stainless steel crown – Primary tooth	\$105.00
D2931	Prefabricated stainless steel crown – Permanent tooth	\$105.00
D2932	Prefabricated resin crown	\$130.00
D2933	Prefabricated stainless steel crown with resin window	\$155.00
D2934	Prefabricated esthetic coated stainless steel crown – Primary tooth	\$155.00
D2940	Protective restoration	\$15.00
D2941	Interim therapeutic restoration - Primary dentition	\$15.00
D2950	Core buildup – Including any pins	\$105.00
D2951	Pin retention – Per tooth – In addition to restoration	\$23.00
D2952	Post and core – In addition to crown, indirectly fabricated	\$165.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D2954	Prefabricated post and core – In addition to crown	\$140.00
D2960	Labial veneer (resin laminate) – Direct	\$105.00
D2976	Band stabilization – Per tooth	\$0.00
D2980	Crown repair necessitated by restorative material failure	\$15.00
D2983	Veneer repair necessitated by restorative material failure	\$15.00
D2989	Excavation of a tooth resulting in the determination of non-restorability	\$155.00
D2991	Application of hydroxyapatite regeneration medicament - Per tooth	\$17.00
D6210	Pontic – Cast high noble metal	\$470.00
D6211	Pontic – Cast predominantly base metal	\$425.00
D6212	Pontic – Cast noble metal	\$450.00
D6214	Pontic – Titanium and titanium alloys	\$480.00
D6240	Pontic – Porcelain fused to high noble metal	\$470.00
D6241	Pontic – Porcelain fused to predominantly base metal	\$425.00
D6242	Pontic – Porcelain fused to noble metal	\$450.00
D6243	Pontic – Porcelain fused to titanium and titanium alloys	\$470.00
D6245	Pontic – Porcelain/ceramic	\$470.00
D6602	Retainer inlay – Cast high noble metal, 2 surfaces	\$460.00
D6603	Retainer inlay – Cast high noble metal, 3 or more surfaces	\$480.00
D6604	Retainer inlay – Cast predominantly base metal, 2 surfaces	\$405.00
D6605	Retainer inlay – Cast predominantly base metal, 3 or more surfaces	\$415.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D6606	Retainer inlay – Cast noble metal, 2 surfaces	\$430.00
D6607	Retainer inlay – Cast noble metal, 3 or more surfaces	\$440.00
D6610	Retainer onlay – Cast high noble metal, 2 surfaces	\$460.00
D6611	Retainer onlay – Cast high noble metal, 3 or more surfaces	\$480.00
D6612	Retainer onlay – Cast predominantly base metal, 2 surfaces	\$405.00
D6613	Retainer onlay – Cast predominantly base metal, 3 or more surfaces	\$415.00
D6614	Retainer onlay – Cast noble metal, 2 surfaces	\$430.00
D6615	Retainer onlay – Cast noble metal, 3 or more surfaces	\$450.00
D6624	Retainer inlay – Titanium	\$470.00
D6634	Retainer onlay – Titanium	\$470.00
D6740	Retainer crown – Porcelain/ceramic	\$525.00
D6750	Retainer crown – Porcelain fused to high noble metal	\$480.00
D6751	Retainer crown – Porcelain fused to predominantly base metal	\$425.00
D6752	Retainer crown – Porcelain fused to noble metal	\$450.00
D6753	Retainer crown – Porcelain fused to titanium and titanium alloys	\$480.00
D6780	Retainer crown – 3/4 cast high noble metal	\$480.00
D6781	Retainer crown – 3/4 cast predominantly base metal	\$425.00
D6782	Retainer crown – 3/4 cast noble metal	\$450.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	\$480.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D6790	Retainer crown – Full cast high noble metal	\$480.00
D6791	Retainer crown – Full cast predominantly base metal	\$425.00
D6792	Retainer crown – Full cast noble metal	\$450.00
D6794	Retainer crown – Titanium and titanium alloys	\$480.00
D6930	Re-cement or re-bond fixed partial denture	\$64.00
	Complex rehabilitation – An additional charge per crown/bridge unit when there are 6 or more units of crown and/or bridge in the same treatment plan – ask your dentist for the guidelines	\$135.00
Endodontics (root canal treatment, excluding final restorations) Gingival and/or osseous regenerative procedures (ie. grafting of gum tissue and/or bone) are limited to one regenerative procedure per site (or per tooth, if applicable).		
D3110	Pulp cap – Direct (excluding final restoration)	\$38.00
D3120	Pulp cap – Indirect (excluding final restoration)	\$38.00
D3220	Pulpotomy – Removal of pulp, not part of a root canal	\$87.00
D3221	Pulpal debridement (not to be used when root canal is done on the same day)	\$87.00
D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	\$87.00
D3310	Anterior root canal – Permanent tooth (excluding final restoration)	\$330.00
D3320	Premolar root canal – Permanent tooth (excluding final restoration)	\$390.00
D3330	Molar root canal – Permanent tooth (excluding final restoration)	\$530.00
D3331	Treatment of root canal obstruction – Nonsurgical access	\$155.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D3332	Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth	\$155.00
D3333	Internal root repair of perforation defects	\$155.00
D3346	Retreatment of previous root canal therapy – Anterior	\$470.00
D3347	Retreatment of previous root canal therapy – Premolar	\$530.00
D3348	Retreatment of previous root canal therapy – Molar	\$675.00
D3410	Apicoectomy/periradicular surgery – Anterior	\$415.00
D3421	Apicoectomy/periradicular surgery – Premolar (first root)	\$455.00
D3425	Apicoectomy/periradicular surgery – Molar (first root)	\$480.00
D3426	Apicoectomy/periradicular surgery (each additional root)	\$165.00
D3430	Retrograde filling per root	\$115.00
D3471	Surgical repair of root resorption – Anterior	\$415.00
D3472	Surgical repair of root resorption – Premolar	\$415.00
D3473	Surgical repair of root resorption – Molar	\$415.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – Anterior	\$415.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – Premolar	\$415.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – Molar	\$415.00
D3911	Intraorifice barrier	\$0.00
D3921	Decoronation or submergence of an erupted tooth	\$415.00

Periodontics (treatment of supporting tissues (gum and bone) of the teeth) - Gingival and/or osseous regenerative procedures (gum tissue and/or bone) are limited to 1 regenerative procedure per site (or per tooth, if applicable).

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) and coverage is restricted to one per tooth per 12 consecutive months. The use of any tools or equipment, including but not limited to handpieces, lasers, scalers, etc., is considered inclusive to the overall covered procedure listed on the Patient Charge Schedule, and cannot be separately charged.		
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	\$270.00
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	\$125.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$125.00
D4240	Gingival flap (including root planing) – 4 or more teeth per quadrant	\$330.00
D4241	Gingival flap (including root planing) – 1 to 3 teeth per quadrant	\$180.00
D4245	Apically positioned flap	\$310.00
D4249	Clinical crown lengthening – Hard tissue	\$365.00
D4260	Osseous surgery – 4 or more teeth per quadrant	\$595.00
D4261	Osseous surgery – 1 to 3 teeth per quadrant	\$350.00
D4263	Bone replacement graft – Retained natural tooth - First site in quadrant	\$290.00
D4264	Bone replacement graft – Retained natural tooth - Each additional site in quadrant	\$225.00
D4266	Guided tissue regeneration, natural teeth – Resorbable barrier per site	\$380.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D4267	Guided tissue regeneration, natural teeth – Nonresorbable barrier per site (includes membrane removal)	\$430.00
D4270	Pedicle soft tissue graft procedure	\$425.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$440.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant or edentulous (<i>missing</i>) tooth position in graft	\$440.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous (<i>missing</i>) tooth position in same graft site	\$220.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor materials) – Each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$220.00
D4286	Removal of non-resorbable barrier	\$86.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant (<i>limited to once per quadrant per consecutive 12 months</i>)	\$115.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant (<i>limited to once per quadrant per consecutive 12 months</i>)	\$64.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – Full mouth, after oral evaluation (<i>limit 1 per calendar year</i>)	\$0.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
	Additional scaling in presence of generalized moderate or severe gingival inflammation – Full mouth, after oral evaluation (<i>limit 2 per calendar year</i>)	\$45.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit (<i>1 per lifetime, unless medically necessary</i>)	\$86.00
D4381	Localized delivery of antimicrobial agents per tooth	\$45.00
D4910	Periodontal maintenance (<i>limit 4 per calendar year (only covered after active periodontal therapy)</i>)	\$78.00
	Additional periodontal maintenance procedures (beyond 4 per calendar year)	\$78.00
	Periodontal charting for planning treatment of periodontal disease	\$0.00
	Periodontal hygiene instruction	\$0.00
D4921	Gingival irrigation with a medicinal agent - Per quadrant	\$0.00
Prosthetics (removable tooth replacement – dentures) - Includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.		
D5110	Full upper denture	\$575.00
D5120	Full lower denture	\$575.00
D5130	Immediate full upper denture	\$615.00
D5140	Immediate full lower denture	\$615.00
D5211	Upper partial denture – Resin base (including retentive/ clasping materials, rests, and teeth)	\$430.00
D5212	Lower partial denture – Resin base (including retentive/ clasping materials, rests, and teeth)	\$430.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D5213	Upper partial denture – Cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$670.00
D5214	Lower partial denture – Cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$670.00
D5221	Immediate upper partial denture – Resin base (including retentive/clasping materials, rests and teeth)	\$430.00
D5222	Immediate lower partial denture – Resin base (including retentive/clasping materials, rests and teeth)	\$430.00
D5223	Immediate upper partial denture – Cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$670.00
D5224	Immediate lower partial denture – Cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$670.00
D5225	Upper partial denture – Flexible base (including retentive/clasping materials, rests and teeth)	\$460.00
D5226	Lower partial denture – Flexible base (including retentive/clasping materials, rests and teeth)	\$460.00
D5227	Immediate upper partial denture - Flexible base (including any clasps, rests and teeth)	\$430.00
D5228	Immediate lower partial denture - Flexible base (including any clasps, rests and teeth)	\$430.00
D5410	Adjust complete denture – Upper	\$38.00
D5411	Adjust complete denture – Lower	\$38.00
D5421	Adjust partial denture – Upper	\$38.00
D5422	Adjust partial denture – Lower	\$38.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
Repairs to prosthetics		
D5511	Repair broken complete denture base - Lower	\$73.00
D5512	Repair broken complete denture base - Upper	\$73.00
D5520	Replace missing or broken teeth – Complete denture (each tooth)	\$73.00
D5611	Repair resin partial denture base - Lower	\$73.00
D5612	Repair resin partial denture base - Upper	\$73.00
D5630	Repair or replace broken retentive/clasping materials - Per tooth	\$92.00
D5640	Replace broken teeth – Per tooth	\$73.00
D5650	Add tooth to existing partial denture	\$73.00
D5660	Add clasp to existing partial denture - Per tooth	\$92.00
Denture relining (limit 1 every 24 months)		
D5710	Rebase complete upper denture	\$220.00
D5711	Rebase complete lower denture	\$220.00
D5720	Rebase upper partial denture	\$220.00
D5721	Rebase lower partial denture	\$220.00
D5725	Rebase hybrid prosthesis	\$440.00
D5730	Reline complete upper denture – Direct	\$130.00
D5731	Reline complete lower denture – Direct	\$130.00
D5740	Reline upper partial denture – Direct	\$130.00
D5741	Reline lower partial denture – Direct	\$130.00
D5750	Reline complete upper denture – Indirect	\$195.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D5751	Reline complete lower denture – Indirect	\$195.00
D5760	Reline upper partial denture – Indirect	\$195.00
D5761	Reline lower partial denture – Indirect	\$195.00
D5765	Soft liner for complete or partial removable denture – Indirect	\$195.00
Interim dentures (limit 1 every 5 years)		
D5810	Interim complete denture – Upper	\$330.00
D5811	Interim complete denture – Lower	\$330.00
D5820	Interim partial denture (including retentive/clasping materials, rests and teeth), upper	\$265.00
D5821	Interim partial denture (including retentive/clasping materials, rests and teeth), lower	\$265.00
D5875	Modification of removable prosthesis following implant surgery	\$230.00
D5876	Add metal substructure to acrylic full denture (per arch)	\$220.00
Implant/abutment supported prosthetics – All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant(s) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years. If your dentist offers same day in-office CAD/CAM (ceramic) services, they may charge an additional fee of no more than \$150.00 per tooth/unit for crowns, bridges, inlays, onlays, post and cores, and veneers. Same day in-office CAD/CAM (ceramic) services refer to dental restorations that are created and delivered in the dental office the same day using a digital impression and an in-office CAD/CAM milling machine.		
D6058	Abutment supported porcelain/ceramic crown	\$815.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$770.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$715.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$740.00
D6062	Abutment supported cast metal crown (high noble metal)	\$770.00
D6063	Abutment supported cast metal crown (predominantly base metal)	\$715.00
D6064	Abutment supported cast metal crown (noble metal)	\$740.00
D6065	Implant supported porcelain/ceramic crown	\$815.00
D6066	Implant supported crown - Porcelain fused to high noble alloys	\$770.00
D6067	Implant supported crown - High noble alloys	\$770.00
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	\$815.00
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (high noble metal)	\$770.00
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal)	\$715.00
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal)	\$740.00
D6072	Abutment supported retainer for cast metal fixed partial denture (high noble metal)	\$770.00
D6073	Abutment supported retainer for cast metal fixed partial denture (predominantly base metal)	\$715.00
D6074	Abutment supported retainer for cast metal fixed partial denture (noble metal)	\$740.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D6075	Implant supported retainer for ceramic fixed partial denture	\$815.00
D6076	Implant supported retainer for fixed partial denture - Porcelain fused to high noble alloys	\$770.00
D6077	Implant supported retainer for metal fixed partial denture - High noble alloys	\$770.00
D6082	Implant supported crown – Porcelain fused to predominantly base alloys	\$715.00
D6083	Implant supported crown – Porcelain fused to noble alloys	\$740.00
D6084	Implant supported crown – Porcelain fused to titanium and titanium alloys	\$770.00
D6085	Interim implant crown	\$135.00
D6086	Implant supported crown – Predominantly base alloys	\$715.00
D6087	Implant supported crown – Noble alloys	\$740.00
D6088	Implant supported crown – Titanium and titanium alloys	\$770.00
D6089	Accessing and retorquing loose implant screw – Per screw	\$82.00
D6092	Re-cement implant/abutment supported crown	\$82.00
D6093	Re-cement implant/abutment supported fixed partial denture	\$103.00
D6094	Abutment supported crown - Titanium and titanium alloys	\$770.00
D6096	Remove broken implant retaining screw	\$82.00
D6097	Abutment supported crown – Porcelain fused to titanium and titanium alloys	\$770.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D6098	Implant supported retainer – Porcelain fused to predominantly base alloys	\$715.00
D6099	Implant supported retainer for fixed partial denture – Porcelain fused to noble alloys	\$740.00
D6106	Guided tissue regeneration – Resorbable barrier, per implant	\$380.00
D6107	Guided tissue regeneration – Non-resorbable barrier, per implant	\$430.00
D6110	Implant /abutment supported removable denture for edentulous arch – Upper	\$875.00
D6111	Implant /abutment supported removable denture for edentulous arch – Lower	\$875.00
D6112	Implant /abutment supported removable denture for partially edentulous arch – Upper	\$970.00
D6113	Implant /abutment supported removable denture for partially edentulous arch – Lower	\$970.00
D6114	Implant /abutment supported fixed denture for edentulous arch – Upper	\$875.00
D6115	Implant /abutment supported fixed denture for edentulous arch – Lower	\$875.00
D6116	Implant /abutment supported fixed denture for partially edentulous arch – Upper	\$970.00
D6117	Implant /abutment supported fixed denture for partially edentulous arch – Lower	\$970.00
D6118	Implant/abutment supported interim fixed denture for edentulous arch – Lower	\$525.00
D6119	Implant/abutment supported interim fixed denture for edentulous arch – Upper	\$525.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D6120	Implant supported retainer – Porcelain fused to titanium and titanium alloys	\$770.00
D6121	Implant supported retainer for metal fixed partial denture – Predominantly base alloys	\$715.00
D6122	Implant supported retainer for metal fixed partial denture – Noble alloys	\$740.00
D6123	Implant supported retainer for metal fixed partial denture – Titanium and titanium alloys	\$770.00
D6194	Abutment supported retainer crown for fixed partial denture - Titanium and titanium alloys	\$770.00
D6195	Abutment supported retainer – Porcelain fused to titanium and titanium alloys	\$770.00
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	\$47.00
D6198	Remove interim implant component	\$0.00
	Complex rehabilitation on implant/abutment supported prosthetic procedures – An additional charge per crown/bridge unit when there are <i>6 or more units of crown and/or bridge in the same treatment – ask your dentist for the guidelines</i>	\$135.00
Oral surgery (includes routine postoperative treatment) Surgical removal of impacted teeth are covered for ages below 15 when medically necessary.		
D7111	Extraction of coronal remnants – Primary tooth	\$53.00
D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	\$53.00
D7210	Extraction, erupted tooth – Removal of bone and/or section of tooth	\$115.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D7220	Removal of impacted tooth – Soft tissue	\$125.00
D7230	Removal of impacted tooth – Partially bony	\$165.00
D7240	Removal of impacted tooth – Completely bony	\$230.00
D7241	Removal of impacted tooth – Completely bony, unusual complications (narrative required)	\$245.00
D7250	Removal of residual tooth roots – Cutting procedure	\$115.00
D7251	Coronectomy – Intentional partial tooth removal, impacted teeth only	\$165.00
D7260	Oroantral fistula closure	\$355.00
D7261	Primary closure of a sinus perforation	\$330.00
D7270	Tooth stabilization of accidentally evulsed or displaced tooth	\$180.00
D7280	Exposure of an unerupted tooth (<i>excluding wisdom teeth</i>)	\$210.00
D7283	Placement of device to facilitate eruption of impacted tooth	\$49.00
D7285	Incisional biopsy of oral tissue – Hard (bone, tooth) (<i>tooth related – not allowed when in conjunction with another surgical procedure</i>)	\$180.00
D7286	Incisional biopsy of oral tissue – Soft (all others) (<i>tooth related – not allowed when in conjunction with another surgical procedure</i>)	\$135.00
D7287	Exfoliative cytological sample collection	\$78.00
D7288	Brush biopsy – Transepithelial sample collection	\$78.00
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	\$115.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	\$56.00
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	\$155.00
D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	\$74.00
D7450	Removal of benign odontogenic cyst or tumor – Up to 1.25 cm	\$195.00
D7451	Removal of benign odontogenic cyst or tumor – Greater than 1.25 cm	\$195.00
D7471	Removal of lateral exostosis – Maxilla or mandible	\$215.00
D7472	Removal of torus palatinus	\$215.00
D7473	Removal of torus mandibularis	\$215.00
D7485	Reduction of osseous tuberosity	\$155.00
D7510	Incision and drainage of abscess – Intraoral soft tissue	\$74.00
D7511	Incision and drainage of abscess – Intraoral soft tissue – Complicated	\$115.00
D7880	Occlusal orthotic device, by report - <i>(limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)</i>	\$455.00
D7881	Occlusal orthotic device adjustment	\$38.00
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	\$0.00
D7961	Buccal/labial frenectomy (frenulectomy)	\$14.00
D7963	Frenuloplasty	\$20.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
Orthodontics (tooth movement) - The Patient Charge for your entire orthodontic case, including retention, will be based upon the applicable charge in effect on the date your orthodontic treatment begins (banding/ appliance insertion). Coverage is provided for twenty-four (24) months of active treatment. Cases beyond 24 months require an additional payment by the patient.		
D8010	Limited orthodontic treatment of the primary dentition - Banding	\$480.00
D8020	Limited orthodontic treatment of the transitional dentition – Banding	\$480.00
D8030	Limited orthodontic treatment of the adolescent dentition – Banding	\$230.00
D8040	Limited orthodontic treatment of the adult dentition – Banding	\$260.00
D8070	Comprehensive orthodontic treatment of the transitional dentition – Banding	\$500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition – Banding	\$515.00
D8090	Comprehensive orthodontic treatment of the adult dentition – Banding	\$515.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$66.00
D8670	Periodic orthodontic treatment visit	
	Children – Up to 19th birthday:	
	24-month treatment fee	\$2,472.00
	Charge per month for 24 months	\$103.00
	Adults:	

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
	24-month treatment fee	\$3,336.00
	Charge per month for 24 months	\$139.00
D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	\$345.00
D8681	Removable orthodontic retainer adjustment	\$0.00
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	\$175.00
D8999	Unspecified orthodontic procedure – By report <i>(orthodontic treatment plan and records including all necessary images)</i>	\$195.00
General anesthesia/IV sedation: coverage is provided when medically necessary for covered surgical procedures listed on the Patient Charge Schedule. Clinical guidelines related to the use of general anesthesia/IV sedation should be discussed with your treating network specialist.		
D9215	Local anesthesia	\$0.00
D9222	Deep sedation/general anesthesia – First 15 minutes	\$95.00
D9223	Deep sedation/general anesthesia – Each subsequent 15 minute increment	\$95.00
D9230	Inhalation of nitrous oxide / analgesia, anxiolysis	\$60.00
D9239	Intravenous moderate (conscious) sedation/anesthesia – First 15 minutes	\$95.00
D9243	Intravenous moderate (conscious) sedation/analgesia - Each subsequent 15 minute increment	\$95.00
D9613	Infiltration of sustained release therapeutic drug, per quadrant <i>(patient charge is per quadrant)</i>	\$50.00
D9910	Application of desensitizing medicament	\$15.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	\$0.00
Emergency services		
D9110	Palliative treatment of dental pain – Per visit	\$48.00
D9440	Office visit – After regularly scheduled hours	\$77.00
Miscellaneous services		
D9912	Pre-visit patient screening	\$0.00
D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	\$87.00
D9939	Placement of a custom removable clear plastic temporary aesthetic appliance	\$27.00
D9941	Fabrication of athletic mouthguard (<i>limit 1 per 12 months</i>)	\$110.00
D9943	Occlusal guard adjustment	\$0.00
D9944	Occlusal guard – Hard appliance, full arch (<i>limited to 1 D9944, D9945 or D9946 per 24 months</i>)	\$285.00
D9945	Occlusal guard – Soft appliance, full arch (<i>limited to 1 D9944, D9945 or D9946 per 24 months</i>)	\$145.00
D9946	Occlusal guard – Hard appliance, partial arch (<i>limited to 1 D9944, D9945 or D9946 per 24 months</i>)	\$170.00
D9951	Occlusal adjustment – Limited	\$56.00
D9952	Occlusal adjustment – Complete	\$260.00
D9961	Duplicate/copy patient's records	\$0.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays (<i>all other methods of bleaching are not covered</i>)	\$165.00

Cigna Dental Care Plan

Patient Charge Schedule (WI-09 AZ)

Code	Procedure Description	Patient Charge
D9990	Certified translation or sign language services, per visit	\$0.00
D9995	Teledentistry – Synchronous; real-time encounter	\$0.00
D9996	Teledentistry – Asynchronous; information stored and forwarded to dentist for subsequent review	\$0.00
This may contain CDT Dental Procedure Codes and/or portions of, or excerpts from the Code on Dental Procedures and Nomenclature (CDT Code) contained within the current version of the “Dental Procedure Codes”, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.		

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling the toll free number listed on your ID card or plan materials.

Multiple ways to locate a Network General Dentist:

- On-line provider directory at **Cigna.com**®
- On-line provider directory on **myCigna.com**®
- Call the number located on your ID card to:
 - Use the Dental Office Locator via Speech Recognition
 - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any dental office, dental clinic, or other comparable facility. Emergency dental care is limited to services to evaluate, diagnose, and relieve pain or stabilize your emergent oral condition. You should then return to your Network General Dentist for evaluation and determination of any follow up care that you may require. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.



Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative. Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT.) (CHLIC), Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries, including Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., **Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes**, Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In Utah, all products and services are provided by Cigna Health and Life Insurance Company (Bloomfield, CT).

Make Eye Health a Priority with VSP!

Your health comes first with VSP and Valley Schools Employee Benefits Group. Take a look at your VSP vision care coverage.



VSP members save an annual average of

\$489*

More Ways to Save

Extra **\$20** to spend on
Featured Frame Brands†

bebe Calvin Klein COLE HAAN
©DRAGON FLEXON LONGCHAMP

 and more

Up to **40%** Savings on
lens enhancements‡

See all brands and offers
at vsp.com/offers.

Enroll through your employer today.
Questions?
vsp.com

800.877.7195 (TTY: 711)

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

With private practice doctors, Visionworks®, and Eyemart Express retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.



Using your benefit is easy!

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.



Scan QR code or visit vsp.com
to learn more.

*Plan year begins in July

†Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible.

‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available in all states.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on vsp.com. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

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VSP, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare™ and VSP Premier Edge are trademarks of Vision Service Plan. All other brands or marks are the property of their respective owners. 136668 VCCM

Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through Valley Schools Employee Benefits Group. Get coverage for essentials, or upgrade to enhance your coverage options.

Provider Network:

VSP Choice

Effective Date:

07/01/2026



BENEFIT	DESCRIPTION	COPAY
Base Plan Coverage with a VSP Doctor		
WELLVISION EXAM	- Focuses on your eyes and overall wellness - Routine retinal screening - Every plan year*	\$10 Up to \$39
ESSENTIAL MEDICAL EYE CARE	- Retinal imaging for members with diabetes covered-in-full - Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. - Coordination with your medical coverage may apply. Ask your VSP network doctor for details. - Available as needed	\$20 per exam
PRESCRIPTION GLASSES \$25		
FRAME*	\$180 Featured Frame Brands allowance \$160 frame allowance 20% savings on the amount over your allowance \$160 Walmart/Sam's Club/Costco frame allowance - Every other plan year	Included in Prescription Glasses
LENSES	- Single vision, lined bifocal, and lined trifocal lenses - Impact-resistant lenses for dependent children - Every plan year	Included in Prescription Glasses
LENS ENHANCEMENTS	- Standard progressive lenses - Premium progressive lenses - Custom progressive lenses - Scratch-resistant coating - Average savings of 30% on other lens enhancements - Every plan year	\$0 \$95 - \$105 \$150 - \$175 \$0
CONTACTS (INSTEAD OF GLASSES)	\$150 allowance for contacts; copay does not apply - Contact lens exam (fitting and evaluation) - Every plan year	Up to \$60
VSP LIGHTCARE™	\$160 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts. - Every plan year	\$25

BENEFIT	DESCRIPTION	COPAY
Buy-Up Plan Coverage with a VSP Provider		
WELLVISION EXAM	- Focuses on your eyes and overall wellness - Routine retinal screening - Every plan year*	\$10 Up to \$39
ESSENTIAL MEDICAL EYE CARE	- Retinal imaging for members with diabetes covered-in-full - Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. - Coordination with your medical coverage may apply. Ask your VSP network doctor for details. - Available as needed	\$20 per exam
PRESCRIPTION GLASSES \$10		
FRAME*	\$245 Featured Frame Brands allowance \$225 frame allowance 20% savings on the amount over your allowance \$225 Walmart/Sam's Club/Costco frame allowance - Every plan year	Included in Prescription Glasses
LENSES	- Single vision, lined bifocal, and lined trifocal lenses - Impact-resistant lenses for dependent children - Every plan year	Included in Prescription Glasses
LENS ENHANCEMENTS	- Standard progressive lenses - Premium progressive lenses - Custom progressive lenses - Scratch-resistant coating - UV protection - Average savings of 30% on other lens enhancements - Every plan year	\$0 \$40 \$40 \$0 \$0
CONTACTS (INSTEAD OF GLASSES)	\$175 allowance for contacts; copay does not apply - Contact lens exam (fitting and evaluation) - Every plan year	Up to \$60
VSP LIGHTCARE™	\$225 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts. - Every plan year	\$10

ADDITIONAL SAVINGS	Glasses and Sunglasses - Discover all current eyewear offers and savings at vsp.com/offers. 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.
	Laser Vision Correction Average of 15% off the regular price; discounts available at contracted facilities.
	Exclusive Member Extras for VSP Members - Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers. - Save up to 60% on digital hearing aids with TruHearing®. Visit vsp.com/offers/special-offers/hearing-aids for details. - Enjoy everyday savings on health, wellness, and more with VSP Simple Values.

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam	up to \$45	Lined Bifocal Lenses	up to \$50	Progressive Lenses	up to \$50
Frame	up to \$70	Lined Trifocal Lenses	up to \$65	Contacts	up to \$105
Single Vision Lenses	up to \$30				

*Plan year begins in July

¡Haga de la salud de la vista una prioridad con VSP!

Su salud es lo primero con VSP y Valley Schools Employee Benefits Group. Eche un vistazo a su cobertura de atención de VSP cuidado de la visión.



Los miembros de VSP ahorran un promedio anual de

\$489*

Más formas de ahorrar

Más **\$20** para gastar en marcas destacadas de amazones†

bebe Calvin Klein COLE HAAN
 DRAGON FLEXON LONGCHAMP
 Nike y más

Hasta **40%** de ahorros en mejoras para los lentes‡

Vea todas las marcas y ofertas en es.vsp.com/offers.

Los exámenes de la vista de rutina salvaron vidas.

¿Sabía que un examen de la vista es la única manera no invasiva de ver los vasos sanguíneos de su cuerpo? El médico de la red de VSP® puede detectar signos de más de 270 afecciones médicas durante su examen ocular anual, incluyendo diabetes y presión arterial alta, así como afecciones oculares como glaucoma y enfermedad ocular diabética.**

Ahorros que le encantarán.

Vea y luzca bien sin gastar mucho dinero. Los miembros de VSP reciben ahorros exclusivos en marcas de monturas y lentes de contacto populares, además de descuentos adicionales en procedimientos como LASIK, entre otros.

¡La decisión es suya!

VSP le ofrece miles de opciones dentro de la red, incluidos médicos de práctica privada, cadenas minoristas de óptica regionales y nacionales, o en línea en eyeconic.com®. Obtendrá el máximo provecho de sus beneficios en una ubicación de VSP Premier Edge™.

Obtenga más en los lugares preferidos con médicos dentro de la red

médicos de práctica privada Visionworks EYEMART EXPRESS

¡Usar su beneficio es fácil!

Cree una cuenta en es.vsp.com para ver su cobertura dentro de la red, encontrar un médico de la red VSP que sea adecuado para usted y descubrir ahorros con más opciones exclusivas para los miembros. En su cita, solo dígales que tiene VSP.

Inscríbase a través de su empleador hoy.
 ¿Tiene alguna pregunta?
es.vsp.com
 866.673.0307 (TTY: 711)



Escanee el código QR o visite es.vsp.com obtener más información.

*El año del plan inicia en julio

†Las marcas de monturas y las promociones están sujetas a cambios. Disponible solo para miembros de VSP con beneficios del plan aplicables. Únicamente disponible en ubicaciones dentro de la red. Los miembros con un plan financiado por Medicaid o el estado no son elegibles. †Ahorros basados en el precio minorista del médico y varían por plan y elección de compra, el promedio de ahorros se determina después de que se aplican los beneficios. Hable con su médico de la red de VSP para obtener más información.

‡Basado en promedios estatales y nacionales para exámenes de la vista y las marcas más compradas. Este es el ahorro promedio para los miembros de VSP con un plan de servicio completo con un proveedor dentro de la red. Sus ahorros reales dependerán de los anteojos que elija, el plan disponible para usted, el oftalmólogo que visite, sus copagos, su prima y si se deduce de su cheque de pago antes de impuestos. Fuente: Datos de reclamos pagados de la cartera de clientes de VSP de agosto a enero de cada año anterior. **Imagen completa de la salud de la vista, American Optometric Association, 2020. +La cobertura con una cadena de establecimientos puede ser diferente o no aplicarse.

VSP garantiza la satisfacción de los miembros únicamente con los proveedores de la red de VSP. La información de la cobertura está sujeta a cambios. Si hubiera algún conflicto entre esta información y el contrato que tiene su organización con VSP, prevalecerán los términos del contrato. Dependiendo de las leyes aplicables, los beneficios pueden variar por zona. En el estado de Washington, VSP Vision Care, Inc., es el nombre legal de la corporación por medio de la cual VSP hace negocios. TruHearing no está disponible directamente de VSP en los estados de California y Washington. VSP Premier Edge no está disponible en todos los estados.

Para conocer sus derechos de privacidad y cómo se puede usar su información de salud protegida, consulte el aviso de prácticas de privacidad de VSP en es.vsp.com. La familia de tiendas Visionworks, Eyeconic y Eyemart Express son compañías afiliadas a VSP.

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VSP, Eyeconic y WellVision Exam son marcas comerciales registradas y VSP LightCare™ y VSP Premier Edge son marcas comerciales de Vision Service Plan. Flexon y Dragon son marcas comerciales registradas de Marchon Eyewear, Inc. Todas las demás marcas son marcas o marcas registradas de sus respectivos propietarios. 136668 VCCM

Clasificación: Restringido

Resumen de sus beneficios de atención de la vista de VSP

Priorice su salud y su presupuesto con un plan VSP a través de Valley Schools Employee Benefits Group. Obtenga cobertura para lo esencial o actualice para mejorar sus opciones de cobertura.

RED DE PROVEEDORES:

VSP Choice

FECHA DE VIGENCIA:

07/01/2026



BENEFICIO	DESCRIPCIÓN	COPAGO
Estándar cobertura con un médico de VSP		
WELLVISION EXAM	- Se concentra en sus ojos y bienestar general - Imágenes de retina de rutina - Cada año del plan *	\$10 Hasta \$39
ESSENTIAL MEDICAL EYE CARE (ATENCIÓN MÉDICA ESENCIAL PARA LA VISION)	- Las imágenes de retina para los miembros con diabetes están totalmente cubiertas - Otros exámenes y servicios que no son atención de rutina para tratar problemas inmediatos desde conjuntivitis hasta cambios repentinos de la vista o para monitorear condiciones continuas como ojos secos, enfermedad de ojo diabético, glaucoma y más. - Puede ser necesario coordinar con su cobertura de seguro médico. Consulte con su médico de la red VSP para obtener más información. - Disponible según se necesite	\$20 por examen

ANTEOJOS DE RECETA		\$25
ARMAZÓN*	- Asignación de \$180 para Marcas de Armazones Fabulosas - Asignación de \$160 armazones - Ahorro de 20% sobre el monto que exceda su asignación - Asignación de \$160 en Walmart/Sam's Club/Costco - Cada dos años del plan	Incluido(s) en Anteojos de receta
LENTEs	- Lentes de visión sencilla, bifocal con línea y trifocal con línea - Lentes resistentes a impactos para hijos dependientes - Cada año del plan	Incluido(s) en Anteojos de receta
MEJORAS DE LENTES	- Lentes progresivos estándar - Lentes progresivos de primera calidad - Lentes progresivos personalizados - Recubrimiento contra rayones - Ahorro promedio de 30% en otras mejoras de lentes - Cada año del plan	\$0 \$95 - \$105 \$150 - \$175 \$0
LENTEs DE CONTACTO (EN VEZ DE ANTEOJOS)	\$150 de asignación para lentes de contacto; no aplica copago - Examen para lentes de contacto (ajuste y evaluación) - Cada año del plan	Hasta \$60
VSP LIGHTCARE™	\$160 de asignaciones para anteojos de sol sin receta, listos para usar, o anteojos con filtro para luz azul sin receta, listos para usar, en vez de anteojos o lentes de contacto recetados. - Cada año plan	\$25

BENEFICIO	DESCRIPCIÓN	COPAGO
Premium cobertura con un médico de VSP		
WELLVISION EXAM	- Se concentra en sus ojos y bienestar general - Imágenes de retina de rutina - Cada año del plan *	\$10 Hasta \$39
ESSENTIAL MEDICAL EYE CARE (ATENCIÓN MÉDICA ESENCIAL PARA LA VISION)	- Las imágenes de retina para los miembros con diabetes están totalmente cubiertas - Otros exámenes y servicios que no son atención de rutina para tratar problemas inmediatos desde conjuntivitis hasta cambios repentinos de la vista o para monitorear condiciones continuas como ojos secos, enfermedad de ojo diabético, glaucoma y más. - Puede ser necesario coordinar con su cobertura de seguro médico. Consulte con su médico de la red VSP para obtener más información. - Disponible según se necesite	\$20 por examen

ANTEOJOS DE RECETA		\$10
ARMAZÓN*	- Asignación de \$245 para Marcas de Armazones Fabulosas - Asignación de \$225 armazones - Ahorro de 20% sobre el monto que exceda su asignación - Asignación de \$225 en Walmart/Sam's Club/Costco - Cada año del plan	Incluido(s) en Anteojos de receta
LENTEs	- Lentes de visión sencilla, bifocal con línea y trifocal con línea - Lentes resistentes a impactos para hijos dependientes - Cada año del plan	Incluido(s) en Anteojos de receta
MEJORAS DE LENTES	- Lentes progresivos estándar - Lentes progresivos de primera calidad - Lentes progresivos personalizados - Recubrimiento contra rayones - Protección contra rayos UV - Ahorro promedio de 30% en otras mejoras de lentes - Cada año del plan	\$0 \$40 \$40 \$0 \$0
LENTEs DE CONTACTO (EN VEZ DE ANTEOJOS)	\$175 de asignación para lentes de contacto; no aplica copago - Examen para lentes de contacto (ajuste y evaluación) - Cada año del plan	Hasta \$60
VSP LIGHTCARE™	\$225 de asignaciones para anteojos de sol sin receta, listos para usar, o anteojos con filtro para luz azul sin receta, listos para usar, en vez de anteojos o lentes de contacto recetados. - Cada año plan	\$10

AHORROS ADICIONALES	Anteojos y anteojos de sol
	- Descubra todas las ofertas y ahorros disponibles para anteojos y lentes es.vsp.com/offers. 20 % de ahorros en más pares ilimitados de anteojos/anteojos de sol con o sin receta, incluyendo mejoras de lentes, de un proveedor de VSP en el plazo de 12 meses después de su último WellVision Exam.
	Corrección láser de la vista Promedio de 15% de descuento del precio regular; los descuentos sólo disponibles en los establecimientos contratados.
Extras exclusivos para miembros de VSP	
- Ahorre hasta un 60 % en un aparato auditivo digital con TruHearing®. Visite es.vsp.com/offers/special-offers/hearing-aids para obtener más información. - Descubra todas las ofertas y ahorros disponibles para anteojos y lentes es.vsp.com/offers. - Ahorros diarios en salud y bienestar, y más con VSP Simple Values.	

COBERTURA CON UN MÉDICO FUERA DE LA RED

Con tantas opciones dentro de la red, VSP hace que sea fácil aprovechar al máximo sus beneficios. Tendrá acceso a las opciones de práctica privada, tienda y opciones en línea que prefiera dentro de la red. Inicie sesión en es.vsp.com para buscar un proveedor dentro de la red. Su plan incluye reembolsos fuera de la red:

* El año del plan comienza en julio

Employer-paid Life and Accidental Death and Dismemberment (AD&D)

Valley Schools Employee Benefits Group - Deer Valley Unified School District | All Eligible Administrators and All Other Eligible Employees | Policy #931407

Protect your family

Life insurance provides the people you love with financial support when you can't be there—and when they need it most.

How it works

Your employer is providing coverage for you, at no cost to you!

Benefits

For you	One times your basic annual earnings, up to a maximum of \$150,000—with no medical questions asked. (Minimum benefit is \$20,000). Benefits are reduced to 50% at age 70. Your coverage ends at termination of employment or retirement.
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Reasons why you may need life insurance



Provide financial support for others



Pay household expenses



Pay tuition



Leave an inheritance or philanthropic gift



Pay funeral or medical expenses



Sun Life Assurance Company of Canada
sunlife.com
800-247-6875

Accidental Death and Dismemberment (AD&D)

This coverage includes an equal amount of AD&D insurance that provides a benefit if you suffer a covered accidental injury or die from a covered accident.	Benefits – This is a partial list. Refer to the certificate for the full list of covered accidental injuries.			
	Accidental injury	The plan pays	Accidental injury	The plan pays
	Accidental death	100%	Loss of speech only or hearing only	50%
	Quadriplegia	100%	Loss of limb (arm or leg)	50%
	Loss of sight of one eye	50%	Loss of thumb and index finger on same hand	25%

Additional considerations

If I become terminally ill	You may apply to receive a portion of your life insurance to help cover medical and living expenses. This is not long-term-care insurance. It will reduce the total amount of the life insurance payment we pay to your beneficiary(ies). Receipt of the Accelerated Benefit may be taxable and may affect your eligibility for public assistance programs.
If I become Totally Disabled	If we determine that you are Totally Disabled and cannot work, your life insurance coverage may continue at no cost. You must meet certain requirements, as detailed in the Certificate.
If I leave my employer	Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Life and AD&D FAQ

How is my benefit claim filed and paid?

You or your beneficiary(ies) and your employer will complete the appropriate claims forms and submit these to Sun Life. Our claims examiners review the claim and gather additional information if necessary. We will notify you or your beneficiaries when the decision is made. If your death claim is approved, beneficiaries may

elect to receive a lump sum payment or to have the benefit paid into an account where the funds accumulate interest and can be withdrawn at any time. (State restrictions apply and options may vary by state.) If your AD&D claim for an accidental injury is approved, the benefit amount will be paid directly to you.

Read the important plan provisions section for more information including limitations and exclusions.

Important plan provisions

The following coverage(s) do not constitute comprehensive health insurance (often referred to as “major medical coverage”) and do not satisfy the requirement for Minimum Essential Coverage under the Affordable Care Act. They do NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services.

To become insured, all persons must be actively at work and performing their regular duties at their usual place of business on the proposed effective date or their date of coverage will be deferred until they return to active work. Refer to the Certificate for details and similar requirements for dependent coverage.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Accidental Death and Dismemberment

We will not pay a benefit that is due to or results from: suicide while sane or insane; injuring oneself intentionally; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; voluntary use of any controlled substance/illegal drugs; operation of a motorized vehicle while intoxicated; bodily or mental infirmity or disease or infection unless due to an accidental injury; riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

Sun Life Financial companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, “Sun Life Financial” or “Sun Life”).

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 12-GP-01, 13-ADD-C-01, 15-GP-01, 15-LF-C-01, 15-ADD-C-01, 12-DI-C-01, 16-DI-C-01, TDBPOLICY-2006, TDI-POLICY, 12-AC-C-01, 16-AC-C-01, 12-SD-C-01, 16-SD-C-01, and 16-CAN-C-01.

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GVBH-EE-6701



Voluntary Life insurance

Valley Schools Employee Benefits Group - Deer Valley Unified School District | All Eligible Board Members | Policy #931407

Protect your family

The people you love and support could face financial challenges if you were no longer around. Life insurance provides your loved ones with money they can use for household expenses, tuition, mortgage payments and more.

How it works

You have the opportunity to purchase additional life insurance, beyond what your employer has provided for you. Your employer is offering you and your coworkers this coverage as a group, at a group rate. You are responsible for paying all or a portion of the cost. Choose the benefit that best meets your needs and your budget.

Benefits

For you	You can choose from \$10,000 to \$50,000—in increments of \$10,000—with no medical questions asked. (For new hires only. Late entrants are required to answer medical questions. See FAQ.) The benefit amount is reduced to 50% at age 70. Your coverage ends at termination of employment or retirement.
For your spouse	You can choose from \$5,000 to \$50,000—in increments of \$5,000—with no medical questions asked up to the Guaranteed Issue amount of \$30,000. (For new hires only. Late entrants are required to answer medical questions. See FAQ.) (The amount you select for your spouse cannot exceed 100% of your coverage amount.) Coverage ends when your spouse turns age 65. The benefit amount may be reduced when the employee benefit amount is reduced.
For your child(ren)	You can choose from \$2,000 to \$10,000—in \$2,000 increments—with no medical questions asked. A full benefit is payable for a dependent child who is 6 months to to age 26. A reduced benefit is payable for a child from 15 days to 6 months.



What does life insurance mean for the Jones family?

Jason and Charlotte just bought their first house and are expecting their first child. They didn't think they could afford life insurance—and they didn't think they needed it because they're young and healthy.

However, Jason's best friend from high school was recently killed in a car accident. Sadly, his wife is selling their home because she can't afford the mortgage on her own.

Jason and Charlotte started to rethink life insurance, and were surprised to find options at work that meet their budget.

Since most people would have trouble paying living expenses after several months if their primary wage earner died, it may be worth asking, who depends on you?*



Additional considerations

If I become terminally ill	You may apply to receive a portion of your life insurance to help cover medical and living expenses. This is not long-term-care insurance. It will reduce the total amount of the life insurance payment we pay to your beneficiary(ies). Receipt of the Accelerated Benefit may be taxable and may impact your eligibility for public assistance programs.
If I become Totally Disabled	If we determine that you are Totally Disabled and cannot work, your life insurance coverage may continue at no cost. You must meet certain requirements, as detailed in the Certificate.
If I leave my employer	Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.
If I've had a life change	You may be able to adjust your coverage as your needs change (e.g., you get married or have a baby). Certain changes require you to answer health questions. Ask your employer for details.

Life FAQ

Do I have to answer health questions to enroll?

You will be required to answer health questions if (1) you do not elect coverage when it's first available to you and you want to elect at a later date; (2) you request an amount higher than the Guaranteed Issue amount noted in the table, if offered; or (3) you want to increase coverage at a later date. You will need to fill out and submit our Evidence of Insurability application which must be approved by Sun Life before the coverage takes effect.

How is my benefit claim filed and paid?

You or your beneficiary(ies) and your employer will complete the appropriate claims forms and submit these to Sun Life. Our claims examiners review the claim and gather additional information if necessary. We will notify you or your beneficiaries when the decision is made. If your death claim is approved, beneficiaries may elect to receive a lump sum payment or to have the benefit paid into an account where the funds accumulate interest and can be withdrawn at any time. (State restrictions apply and options may vary by state.)

Read the important plan provisions section for more information including limitations and exclusions.

* Facts About Life 2016, LIMRA.com, September 2016, accessed June 2018.

Important plan provisions

The following coverage(s) do not constitute comprehensive health insurance (often referred to as “major medical coverage”) and do not satisfy the requirement for Minimum Essential Coverage under the Affordable Care Act. They do NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services.

To become insured, all persons must be actively at work and performing their regular duties at their usual place of business on the proposed effective date or their date of coverage will be deferred until they return to active work. Refer to the Certificate for details and similar requirements for dependent coverage.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Life

If cause of death is suicide, no amount of contributory Life insurance will be paid if suicide occurs within a specific time period after the insurance or increase in insurance becomes effective. Please see the Certificate for details.

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

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GVBH-EE-6701



Rate Sheet

The chart below shows possible coverage amounts and the corresponding costs per Monthly pay period.
Find your age bracket (as of the effective date of coverage) to determine the associated cost of the coverage amount you choose.

Employee - Coverage and Monthly cost for employee Voluntary Life

Age and Cost														
Coverage Amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
\$10,000	0.50	0.50	0.50	0.68	1.02	1.67	2.40	3.77	5.76	8.98	17.38	37.81	76.79	156.82
\$20,000	1.00	1.00	1.00	1.36	2.04	3.34	4.80	7.54	11.52	17.96	34.76	75.62	153.58	313.64
\$30,000	1.50	1.50	1.50	2.04	3.06	5.01	7.20	11.31	17.28	26.94	52.14	113.43	230.37	470.46
\$40,000	2.00	2.00	2.00	2.72	4.08	6.68	9.60	15.08	23.04	35.92	69.52	151.24	307.16	627.28
\$50,000	2.50	2.50	2.50	3.40	5.10	8.35	12.00	18.85	28.80	44.90	86.90	189.05	383.95	784.10

Spouse - Coverage and Monthly cost for spouse Voluntary Life

Age and Cost										
Coverage Amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
\$5,000	0.25	0.25	0.25	0.34	0.51	0.84	1.20	1.89	2.88	4.49
\$10,000	0.50	0.50	0.50	0.68	1.02	1.67	2.40	3.77	5.76	8.98
\$15,000	0.75	0.75	0.75	1.02	1.53	2.51	3.60	5.66	8.64	13.47
\$20,000	1.00	1.00	1.00	1.36	2.04	3.34	4.80	7.54	11.52	17.96
\$25,000	1.25	1.25	1.25	1.70	2.55	4.18	6.00	9.43	14.40	22.45
\$30,000	1.50	1.50	1.50	2.04	3.06	5.01	7.20	11.31	17.28	26.94
\$35,000	1.75	1.75	1.75	2.38	3.57	5.85	8.40	13.20	20.16	31.43
\$40,000	2.00	2.00	2.00	2.72	4.08	6.68	9.60	15.08	23.04	35.92
\$45,000	2.25	2.25	2.25	3.06	4.59	7.52	10.80	16.97	25.92	40.41
\$50,000	2.50	2.50	2.50	3.40	5.10	8.35	12.00	18.85	28.80	44.90

Spouse rate based on spouse age

Child - Coverage and Monthly cost

Coverage Amounts	Voluntary Life Cost
\$2,000	\$0.27
\$4,000	\$0.54
\$6,000	\$0.82
\$8,000	\$1.09
\$10,000	\$1.36

Employer-paid Short-Term Disability Insurance

Valley Schools Employee Benefits Group - Deer Valley Unified School District | All Eligible Employees | Policy #931407

Protect your paycheck

Imagine you hurt your back, and your doctor recommends you stay home from work for several weeks. Or imagine you just delivered twins. You can't work, but you have bills to pay. Short-term disability replaces part of your income if you can't work for a short time due to a covered disability. You can use the weekly check to help pay everyday expenses, like your mortgage or rent, utilities, childcare and groceries.

How it works

This coverage is provided by your employer at no cost to you!

Benefits

Weekly benefit after your claim is approved	You will receive a check for your benefits on a weekly basis. It will cover 66.67% of your Total Weekly Earnings, up to \$500 per week.
When benefits begin	Benefits begin as soon as 91 days from the date you are unable to work due to an injury and 91 days due to an illness.
Benefits may be paid for	Up to 13 weeks , as long as you are still unable to work due to a covered disability.
Additional plan information	This plan provides a benefit for a disabling illness (including pregnancy) or injury that is not work-related.

*"1 in 4 workers will miss up to 3 months of work due to illness, injury or pregnancy during their career."***



What did Short-Term Disability insurance mean for Joyce?

Joyce was out apple-picking when she fell off the ladder and broke her ankle. Her injury left her unable to work at her job while she had surgery and recovered at home.

- Joyce filed a claim with Sun Life. We reviewed her medical information and job description and approved her claim.
- Joyce started receiving her weekly benefit, which helped her pay rent, buy groceries and cover the co-pays for doctor visits.
- Several weeks later, Joyce was back at work

Top 5

Short-Term Disability diagnoses:

1. Maternity
2. Musculoskeletal
3. Injury
4. Digestive disorders
5. Cancer

Sun Life claims data, July 2018

Sun Life Assurance Company of Canada
sunlife.com
800-247-6875

Additional considerations

If I have other income	Income from other sources may reduce your benefit amount. These sources may include Social Security benefits, disability benefits from retirement, government plans or state disability income such as California SDI; other group disability plans; no-fault benefits, salary continuance or sick leave, and return-to-work earnings. For more information or to determine if Voluntary STD or Contributory STD is appropriate for you, contact your Benefits Administrator.
If I can work while disabled	Your plan is designed to encourage and support your return to work. If you are able to work part-time for example, you may receive part of your benefit while working.
If I become pregnant	Check with your employer to make sure you are eligible for benefits and let them know when you expect to be out of work on maternity leave. Typically a maternity claim is treated as an illness claim (see "When benefits begin" in the table).

Short-term disability FAQs

How do I file a claim after becoming disabled?

Check with your employer to make sure you are eligible for benefits. Then, file a claim with Sun Life. We will ask for information from you about your doctor, your income, and your condition. We will ask for medical records and for your doctor to fill out a form about your condition and your expected recovery. You can download forms from our website or call our toll free number at 888-444-0134 Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET.

How do I qualify for benefits?

You'll start receiving disability payments if you satisfy the Elimination Period (see "When benefits begin" in the table)

and meet the definition of disability if you're insured when you become disabled.

How is my benefit taxed?

If you pay for your coverage all post-tax, your benefit will not be taxable income or tax reported by us to the IRS. If you pay for your coverage all pre-tax, or if you pay for part of your coverage post-tax and your employer pays for the rest, or if your employer pays the entire premium, some or all of your benefit amount will be taxable income, which will be tax reported on a Form W-2 and it may have FICA tax deductions that reduce the amount we pay you. Please consult with a tax advisor or your employer if you have any questions.

Read the important plan provisions section for more information including limitations and exclusions.

**Realitycheckup.org, Council for Disability Awareness, 2018

Important plan provisions

The following coverage(s) do not constitute comprehensive health insurance (often referred to as “major medical coverage”) and do not satisfy the requirement for Minimum Essential Coverage under the Affordable Care Act. They do NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services.

To become insured, all persons must be actively at work and performing their regular duties at their usual place of business on the proposed effective date or their date of coverage will be deferred until they return to active work. Refer to the Certificate for details and similar requirements for dependent coverage.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Short-Term Disability

We will not pay a benefit that is caused by, contributed to in any way or resulting from: intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection. We will not pay a benefit for any accident or sickness covered by Workers’ Compensation or similar law; or for any work-related illness or injuries unless otherwise stated previously; or if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.).

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

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Voluntary Short-Term Disability Insurance

Valley Schools Employee Benefits Group - Deer Valley Unified School District | All Eligible Employees | 937691

Protect your paycheck

Imagine you hurt your back, and your doctor recommends you stay home from work for four weeks. Or imagine you just delivered twins. You can't work, but you have bills to pay. Short-term disability replaces part of your income if you can't work for a short time due to a covered disability. You can use the weekly check to help pay everyday expenses, like your mortgage or rent, utilities, childcare and groceries.

How it works

Your employer is offering you and your coworkers this coverage as a group, at a group rate. You are responsible for paying a portion or all of the cost.

Choose the benefit that best meets your needs and your budget.

Benefits

Weekly benefit after your claim is approved	Get a weekly check of \$100 to \$1,200 , in any \$100 increment you choose, to replace a portion of your income—up to 66.67% of your Total Weekly Earnings.
When benefits begin	Benefits begin as soon as 15 days from the date you are unable to work due to an injury and 15 days due to an illness.
Benefits may be paid for	Up to 11 weeks , as long as you are still unable to work due to a covered disability.
Additional plan information	This plan provides a benefit for a disabling illness (including pregnancy) or injury that is not work-related.

*"1 in 4 workers will miss up to 3 months of work due to illness, injury or pregnancy during their career."***



What did Short-Term Disability insurance mean for Joyce?

Joyce was out apple-picking when she fell off the ladder and broke her ankle. Her injury left her unable to work at her job while she had surgery and recovered at home.

- Joyce filed a claim with Sun Life. We reviewed her medical information and job description and approved her claim.
- Joyce started receiving her weekly benefit, which helped her pay rent, buy groceries and cover the co-pays for doctor visits.
- Six weeks later, Joyce was back at work

Top 5

Short-Term Disability diagnoses:

1. Maternity
2. Musculoskeletal
3. Injury
4. Digestive disorders
5. Cancer

Sun Life claims data, July 2018



Sun Life Assurance Company of Canada
sunlife.com
800-247-6875

Additional considerations

If I have other income	Income from other sources may reduce your benefit amount. These sources may include Social Security benefits, disability benefits from retirement, government plans or state disability income such as California SDI; other group disability plans; no-fault benefits, salary continuance or sick leave, and return-to-work earnings. For more information or to determine if Voluntary STD or Contributory STD is appropriate for you, contact your Benefits Administrator.
If I can work while disabled	Your plan is designed to encourage and support your return to work. If you are able to work part-time for example, you may receive part of your benefit while working.
If I become pregnant	Check with your employer to make sure you are eligible for benefits and let them know when you expect to be out of work on maternity leave. Typically a maternity claim is treated as an illness claim (see "When benefits begin" in the table).

Short-term disability FAQs

What if I have a pre-existing condition?

If you submit a claim within 12 months of your insurance taking effect, or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

How do I file a claim after becoming disabled?

Check with your employer to make sure you are eligible for benefits. Then, file a claim with Sun Life. We will ask for information from you about your doctor, your income, and your condition. We will ask for medical records and for your doctor to fill out a form about your condition and your expected recovery. You can download forms from our website.

How do I qualify for benefits?

You'll start receiving disability payments if you satisfy the Elimination Period (see "When benefits begin" in the table) and meet the definition of disability if you're insured when you become disabled.

How is my benefit taxed?

If you pay for your coverage all post-tax, your benefit will not be taxable income or tax reported by us to the IRS. If you pay for your coverage all pre-tax, or if you pay for part of your coverage post-tax and your employer pays for the rest, or if your employer pays the entire premium, some or all of your benefit amount will be taxable income, which will be tax reported on a Form W-2 and it may have FICA tax deductions that reduce the amount we pay you. Please consult with a tax advisor or your employer if you have any questions.

Read the important plan provisions section for more information including limitations and exclusions.

**Realitycheckup.org, Council for Disability Awareness, 2018

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GVBH-EE-6701



Rate Sheet

Employee – Coverage and **Monthly** cost for Short Term Disability.

The chart below shows possible coverage amounts and corresponding costs per Monthly pay period.

Locate the annual earnings closest to your salary, without exceeding it. The corresponding coverage amount represents the maximum coverage you could select.

Annual Earnings	Weekly Coverage Amounts	Cost
\$7,800	\$100	7.76
\$15,600	\$200	15.52
\$23,399	\$300	23.28
\$31,199	\$400	31.04
\$38,999	\$500	38.80
\$46,798	\$600	46.56
\$54,598	\$700	54.32
\$62,397	\$800	62.08
\$70,197	\$900	69.84
\$77,997	\$1,000	77.60
\$85,796	\$1,100	85.36
\$93,596	\$1,200	93.12

for employees

What is the Employee Assistance Program?

Provided through ComPsych® GuidanceResources®, the Employee Assistance Program (EAP) offers counseling, legal and financial consultation, work-life assistance, and other health and well-being resources.

The EAP is available at no cost to you and your household members to help with emotional, financial, legal or other concerns, whether at work or at home, anytime of the day or night. Just call your designated number or log on to the the EAP website, GuidanceResources® Online, for immediate assistance.

Why would someone use the EAP?

There are many reasons. **Among the most common are:**

1 Feeling overwhelmed by the demands of balancing work and family.

4 Having concerns about **substance misuse** for yourself or a dependent.

2 Experiencing **stress, anxiety** or **depression**.

5 Needing assistance with **child or elder care** concerns.

3 Dealing with **grief** and **loss or separation**.

6 Struggling with **legal or financial** issues.

? Can my children use the EAP?

Yes. The EAP is a benefit for employees and each of their household family members, including children.

What happens when I call?

When you call, you will speak with a GuidanceConsultantSM, a trained intake counselor who will collect some general information about you and discuss your needs. They will then work with you to develop a plan of action and help you schedule appointments or access other services.

What counseling services are provided?

The EAP provides free short-term counseling in person, over the phone or via video call with local providers who can help you with your concerns.

Many issues can be resolved with short-term counseling provided through the EAP. If you need longer-term treatment beyond what the EAP provides, you will be referred to a specialist and given help arranging services.

Strict EAP confidentiality.

No personal information about your participation in the EAP will be provided to your employer without your permission.

24/7 Live Assistance

Call: 866-883-0874
App: GuidanceNow®
Online: [guidanceresources.com](https://www.guidanceresources.com)

TRS: Dial 711
Web ID: VALLEY

→
Scan for more resources





all-in identity and scam protection that never clocks out

Safeguard yourself and your family from evolving identity threats and scams with always-on protection from Allstate — provided by your company as a benefit.

With our **Pro or Pro+ plan**, our enhanced 2026 identity protection features deliver stronger security to help you and your family stay ahead of rising scams and identity fraud. Get 24/7 monitoring, advanced scam detection, and expert support for peace of mind.

2026 benefits highlights:

(See page 2 for expanded features list)

NEW Allstate Scam ProtectionSM

Get powerful, digital defense with scam alerting and education, plus phone and text scam blocking.

Family digital safety

Track loved ones, manage web filtering and screentime, and access mental health support. Plus with a family plan get protection for you and all family “under roof or under wallet” as well as any family member 65 or older.

Full-service identity restoration

If you experience identity fraud, a dedicated specialist is ready to guide you through recovery from start to finish. Plus, you'll get access to personal coaching and our new Identity Fraud Finder to help spot and resolve fraud faster.

scammers are getting smarter

Even the most tech-savvy are falling for AI-powered scams

80%

of scam victims said they thought they could spot a scam before falling for one¹

49%

of scam victims experienced two or more scams in just the past two years¹

95%

of our members were satisfied with the identity theft recovery support they received²

¹ Javelin Strategy and Research, Breaking Barriers to Innovation, 2024

² Allstate Identity Protection internal analysis, 2022

Coverage subject to terms, conditions, and exclusions. Reimbursement limits apply. See full policy for details.

which plan is right for you?

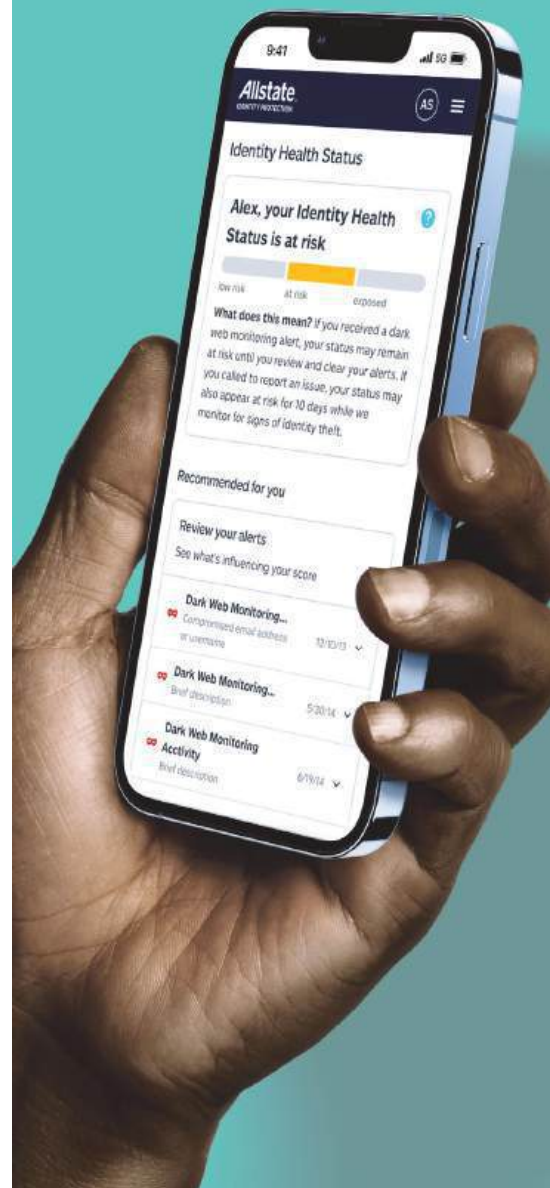
Allstate Identity Protection Pro

- **NEW** In-portal conveniences like one-on-one personal coaching, Identity Fraud Finder, online scheduler and specialist chat
- Identity Health Status gives you at-a-glance insight into your risk
- Allstate Security Pro® delivers updates and education on scams and emerging threats relevant to you
- Comprehensive identity and financial monitoring
- Dark web monitoring
- Social media account takeover monitoring
- TransUnion credit monitoring with annual reporting and credit score
- Coverage can extend to you and family members “under your roof or wallet” plus senior family members aged 65+ who don’t live with you or who are not financially dependent up on you.
- Full-service identity restoration support with up to \$1 million in expense reimbursement for stolen funds and out-of-pocket costs due to identity theft†

Allstate Identity Protection Pro+

All the features of Pro, plus:

- **NEW** Allstate Scam ProtectionSM with alerts and education plus phone and text scam blocking
- **UPGRADED** Up to \$2 million in expense reimbursement for stolen funds and out-of-pocket costs†
- Allstate Digital Footprint®, our proprietary privacy tool, shows where your data lives online and how it might be exposed‡
- Family digital safety tools from Bark that include web filtering, screen time management, and location tracking (family plan required)
 - **NEW** Free access to TalkSpace Go for family plan members and their loved ones including tailored help and \$100 off TalkSpace Therapy
- Tri-bureau credit monitoring with annual reporting and credit score
- Lock your TransUnion credit report in a click and get credit freeze assistance



Plans and pricing

Pro+

\$4.25 per person/month
\$10.95 per family/month

Pro

Complimentary
Individual Plan
8.95 per family/month

Questions?

1-800-789-2720
or visit myaip.com

† Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary and intended for information purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Bark and Talkspace Go are third-party services subject to their own terms, conditions, and availability.

Products and features are subject to change. Certain features require additional activation and may have additional terms.

Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.



Es tu identidad digital. Sé su dueño.

El fraude de identidad puede sucederle a cualquier persona; 39 millones de individuos en los Estados Unidos fueron víctimas de fraude solo en 2023.¹ Desafortunadamente, incluso alguien que sabe cómo minimizar su exposición puede estar en riesgo.

Por eso, tu compañía proporciona numerosos planes de **Allstate Identity Protection** para que elijas como beneficio.

Durante más de 90 años, Allstate ha estado protegiendo lo que más importa. Obtén ahora monitoreo de identidad y resolución de fraudes integrales diseñados para ayudarte a protegerte y proteger a tu familia frente a las amenazas digitales de hoy en día.

Prepárate para lo que viene con:

- ✓ **Monitoreo de identidad, cuentas financieras y crédito**
- ✓ **Herramientas de seguridad digital familiar para ayudar a mantener a los niños seguros^{Δ*}**
- ✓ **Hasta un millón de dólares en reembolso de gastos por robo de identidad[†]**

¹Estudio sobre el fraude de identidad 2024: Resolución de la crisis de identidad destruida, Javelin Strategy & Research.

Obtén protección de identidad para la vida real. Inscríbete durante el periodo de inscripción abierta.

Empezar es fácil

- 1 Inscríbete**
Tienes protección desde la fecha de entrada en vigencia.
- 2 Activa funciones clave**
Explora funciones adicionales en nuestro portal y apps fáciles de usar.
- 3 Vive tu mejor vida en línea**
Te respaldamos con alertas 24/7.



¿Cuál es el plan correcto para ti?

Allstate Identity Protection Pro

- El Estado de Identidad te ofrece una visión general de tu riesgo
- Security Pro de Allstate® ofrece actualizaciones y información sobre estafas y amenazas emergentes relevantes para ti
- Monitoreo exhaustivo de la identidad y las finanzas
- Monitoreo de la *dark web*
- Monitoreo de apropiación de cuentas de redes sociales
- Monitoreo de crédito de TransUnion con informe anual y puntaje crediticio
- Protección para ti y tu familia (todos los que están bajo tu techo o tu billetera)^Δ
- Obtén cobertura familiar senior para padres, suegros y abuelos de más de 65 años, además de acceso a nuestro Centro contra el Fraude a Adultos Mayores con asistencia especializada en estafas^Δ
- Servicio completo de restauración de identidad
- Hasta un millón de dólares en reembolso de gastos por fondos robados y gastos de bolsillo debido al robo de identidad[†]

Allstate Identity Protection Pro+

Obtén todas las funciones de Pro, además de:

- Digital Footprint de Allstate®, nuestra herramienta de privacidad patentada, muestra dónde se encuentra tu información en línea y cómo podría quedar expuesta[‡]
- Bloqueador de llamadas automáticas[‡]
- Bloqueador de anuncios[‡]
- Herramientas de seguridad digital familiar que incluyen filtrado web, gestión del tiempo de pantalla y localización para ayudar a mantener a los niños seguros^{Δ‡}
- Monitoreo de crédito por tres agencias con informe anual y puntaje
- Bloquea tu informe crediticio TransUnion con un clic y obtén asistencia para congelar tu crédito crediticio

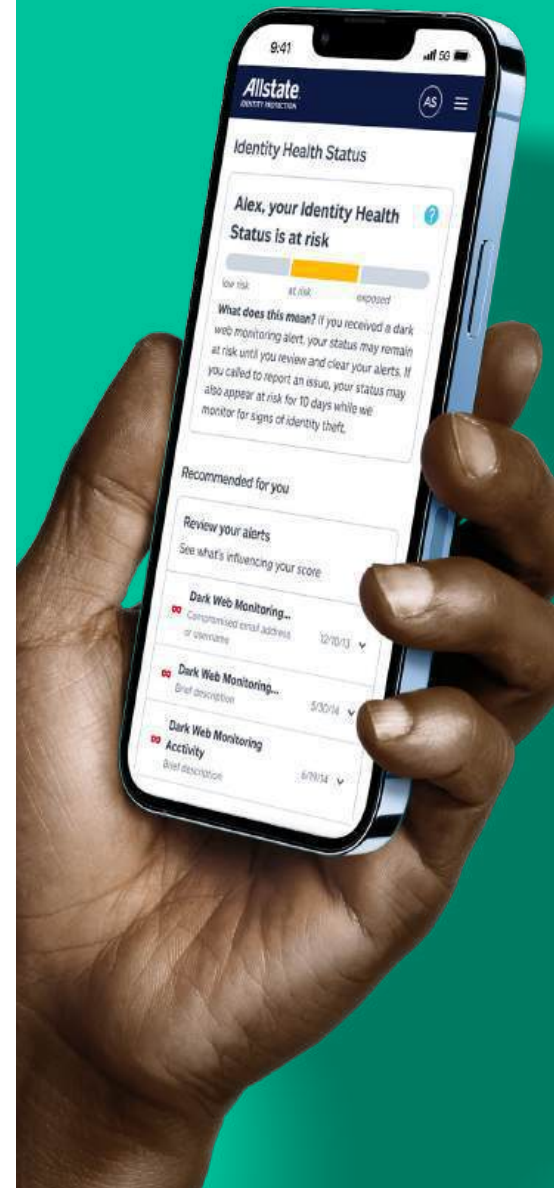
^Δ Solo disponible con un plan familiar.

[‡] Algunas funciones requieren activación adicional. En los planes familiares, la activación de funciones como el bloqueador de llamadas automáticas (hasta 10 números de teléfono), el bloqueador de anuncios, la ciberseguridad (hasta 10 dispositivos) y las funciones de seguridad digital familiar solo puede realizarse a través de la cuenta del suscriptor principal. Las funciones de gestión de la privacidad cubren hasta cinco direcciones de correo electrónico.

[†] El seguro de robo de identidad que cubre el reembolso de gastos y fondos robados está suscrito por American Bankers Insurance Company of Florida, una compañía de Assurant. La presente descripción es un resumen y está destinada únicamente a fines informativos y no incluye todos los términos, condiciones y exclusiones de las pólizas descritas. Por favor, consulta los términos, condiciones y exclusiones de la cobertura en las pólizas reales. La cobertura puede no estar disponible en todas las jurisdicciones.

Los productos y funciones están sujetos a cambios. Ciertas funciones requieren activación adicional y pueden tener términos adicionales.

La Protección de Identidad de Allstate es ofrecida y provista por InfoArmor, Inc, una subsidiaria de The Allstate Corporation.



Planes y precios

Pro+

\$4,25 por persona/mes
\$10,95 por familia/mes

Pro

La cobertura individual es gratuita
\$8,95 por familia/mes

¿Tienes alguna pregunta?

Llama al 1.800.789.2720

o visita myaip.com