Bering Strait School District
A guide to your benefits and enrollment
Bring Healthy Balance back to your life
Finding your perfect balance

Meritain Health knows how important it is that you understand how your benefits work.

That’s why this packet contains:

• Useful information about your benefits plan.
• Everything you need to choose the best options for you and your family.
• Instructions on how to enroll, and to begin using your new benefits.

Why do we feel this is important? Because, let’s face it, living today can be larger than life. Getting through the day at top speed is a sign of our hurry-up, drive-through times. Many people put themselves at the bottom of their to-do lists, giving everything else the best of their energy.

In this way, life gets out of balance. Most of us can keep juggling it all until one day health and well-being begin to pay the price.

Take a deep breath, step back and see the big picture. Help yourself. Put that life on pause for a few minutes, and take the time to read this packet. You’ll see that your employer provides tools, resources and benefits to help you regain your best life and make smart healthcare decisions.

We want to help you get the most from your benefits—so you can live a life that’s balanced and informed.

A balanced life means a healthier you.

These materials were created to help you understand the benefits available to you. This is not a Summary Plan Description and is not intended to replace the benefit summary or schedule of benefits contained within the Plan. If any provision of these materials is inconsistent with the language of the Plan, the language of the Plan will govern. Meritain Health is not an insurer or guarantor of benefits under the Plan.

Advocates for Healthier Living
Meritain Health provides easy-to-use healthcare benefits you can use to stay healthy and productive. Contact us at the number on your ID Card if you have any questions about your plan.
What’s inside?
In this packet, you’ll learn more about the following

Preventive care
- Annual exams and check-ups
- Well-child care
- Immunizations and screenings

Healthcare benefits when you’re sick
- Inpatient and outpatient care
- Home healthcare
- Rehabilitation services
- Doctor visits and prescription drugs with reasonable copays
- Mail order and online prescription options
- A large and convenient provider network
- Dental care
- Vision care

Support when you need it
- www.meritain.com—access easy-to-use decision support tools that help you weigh your care options, and provide cost and quality information.
No surprises, just information

How healthcare reform affects your plan

Your plan is a “grandfathered health plan” under the Affordable Care Act (ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Meritain Health at 1.866.808.2609.

Important things to know about eligibility

Health plans are put together carefully to provide the best benefits possible for participants. Meritain Health knows how important it is for healthcare consumers like you to really understand how your plan works. In this way, you can make the changes you want in your health and in your life. The next section of this packet describes some of the most important provisions of your benefits. It’s another way we’re working with you to help you get the most from your benefits—so you can live a life that’s balanced and informed, with no surprises.

Healthy balance for your family, too

Your family members can reap the rewards of the plan, too. Healthcare benefits are available for every eligible dependent. It’s a great way to help your family members find the right balance between life’s “roller-coaster ride” and their best health. Be sure your family knows about the opportunities open to them—share this packet and other materials you receive from the plan!

Special Enrollment Situations

In these situations, you may be able to add, delete or change your benefit choices.

- Involuntary loss of other benefits
- Marriage
- Birth
- Adoption
- Placement of a child in your home for adoption

If you’re adding a dependent to your benefits through a special enrollment situation, let your employer know within 31 days of the marriage, birth, adoption, etc.; however, this can vary by group.
Your eligible dependents

This benefit plan is open to you and your eligible dependents. An eligible dependent is:

- Your spouse (as defined in your plan documents).
- Your children, natural or adopted.
- Stepchildren.
- A same-sex domestic partner that is living in your home.
- Your same-sex domestic partner’s children.
- Children who have been placed with you for adoption.
- Children for whom you are the legal guardian.

ACA note: Dependent coverage is available for any child (regardless of marital status, residency, student status, etc.) of an employee who is deemed to be the employee’s biological, step, or adopted child (including a child placed for adoption) until the end of the month in which such child reaches age 26.

Please refer to your summary plan description for specific requirements.

Family members covered by a different plan

If a family member is covered by a different plan:

- You can enroll yourself and your eligible dependents in this plan.
- You can enroll yourself in this plan, but decline benefits for some or all dependent(s).
- You can decline benefits for your whole family.

When your dependents are not eligible for benefits under your plan

Tell your employer if:

- You become divorced or are legally separated from a spouse or a same-sex domestic partner who was covered under this plan.
- A dependent child ceases to meet the terms of the plan.

To enroll the dependent for COBRA—a special limited-time plan for continuing benefits at your own expense—you must notify your employer within 60 days of that person’s change in dependent status.

When you have benefits from two group plans

If you or one of your dependents have benefits under both this plan and another plan, the two plans will coordinate your benefits. One plan will be considered the primary plan (or first payer) and the other will be the secondary plan (pays only after the first plan has paid).

Generally, Meritain Health uses a birthday rule to decide which plan would be the primary plan.

The birthday rule

If both parents provide benefits for a child, then the primary plan is the one from the parent whose birthday comes first in the year.

So, if one parent’s birthday is January 12 and the other parent’s is April 1, the primary payer will be the plan from the parent whose birthday comes first—January 12. In the unusual case that both parents have the same birthday, the plan of the parent who has provided benefits longest for the child will be primary.

If you say “no” to this plan now

You can refuse the benefits of this plan, but be sure you’ve looked at the pluses and minuses of that decision. Important: If you don’t enroll now, you’ll have to wait for your employer to offer an open enrollment period.

If you lose other group benefits that you or your dependents might have, and it’s not your fault (for example, the covered person is laid off or let go from a job) you’ll be able to sign up for this plan. Likewise, if you have an event such as your own marriage, divorce, or the birth or adoption of a child, you will have another brief period to sign up for this plan without waiting for your employer’s open enrollment period. These are considered qualifying events.

Open enrollment period

If you waive or decline benefits at first but change your mind later, you can sign up during the time period designated by your employer. Refer to your summary plan description to determine if your plan offers open enrollment.
Balancing Your Life Means Protecting Your Health

Understanding your medical benefits

Chances are, you try every day to restore a healthy balance to your life, but time gets away from you, or other details come first. Meritain Health is here to help you focus, to support you every step of the way. Read about your benefits in the next sections, and learn all you can about using your plan to make healthy changes. Think of the benefits and programs as an important resource in the protection of your body, mind and spirit!

In this section

- Preventive care
- Online tools
- BridgeHealth
- Using your benefits
- Medical management and precertification
- Dental care
- Vision care
- Prescription benefits

Preventive care for you and your family—protecting your healthy balance

Question: Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?

Answer: Nothing makes more sense in these busy times than preventing illness before it happens. That’s why your plan offers excellent benefits for preventive services.

Take an easy step towards good health

Your number one way to help yourself and your family stay healthy is with preventive care. When combined with healthy eating and exercise, vaccines and early detection are your key to a long and healthy life. That’s why your employer offers many preventive treatments at no cost to you when you visit a doctor in your network.
Your Meritain Health member website at www.meritain.com is designed to provide a secure, user and family-friendly, one-stop-shop for you to access the account and claims information you can use to manage your health and wellness.

We’re committed to providing you with all the basics you expect, along with added features to support a healthy lifestyle, assist you with medical decisions, and give insight into the maximization of your healthcare dollars.

Your online tools and resources

With an account you can:

- Look up health and wellness topics.
- Find the status of a claim.
- Find in-network doctors, clinics and hospitals.
- Look up prescription and over-the-counter drug information.
- Order ID Cards.

Your secure member site

First, visit www.meritain.com. Return users, just sign in using your username and password. Then take advantage of the smart, safe resources your health plan offers, right at your fingertips.

New users can create an account by following the easy instructions. You’ll need your health plan ID Card the first time. Remember, each member of your family can have an account, too.

If you need help registering, you can contact Meritain Health Customer Service at 1.866.808.2609

Privacy regulations

Members over 18 years of age have partially protected information according to HIPAA Privacy Regulations.

Members over 18 having difficulty creating an account with their SSN, please contact Meritain Health Customer Service at 1.866.808.2609

Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their PHI for treatment, payment or healthcare operations; and (ii) the health plan’s disclosure of their PHI to persons who may be involved in their healthcare or payment thereof (e.g., family members, close friends).

The BridgeHealth Surgery Benefit™

The plan provides you and your eligible dependents with an option to receive certain surgical procedures through the BridgeHealth Surgery Benefit when a treating physician recommends certain covered expenses and you or your eligible dependent elects to receive treatment at certain medical providers participating in the BridgeHealth Network (“BridgeHealth Providers”). The BridgeHealth Surgery Benefit is only available to you and your eligible dependents if coverage under this plan is primary. If you and/or your eligible dependents have other health coverage that causes this plan to pay secondary you and/or your dependents may not be eligible for benefits under the BridgeHealth Surgery Benefit.

BridgeHealth Surgery Benefit

Your plan has been enhanced to include the BridgeHealth Surgery Benefit giving you access to:

A Centers of Excellence for major planned surgeries and procedures
A Coverage for travel costs for you and a companion
A Provisions to eliminate your out-of-pocket costs
A A dedicated Care Coordinator who provides “concierge” service & support

The BridgeHealth Surgery Benefit includes coverage for the following procedures:

A Cardiac procedures
A Spine surgeries
A Vascular surgeries
A Specific cancer treatments
A Orthopedic surgeries
A Other planned surgeries

If you or family members have the need for a procedure, you will want to explore what the BridgeHealth Surgery Benefit can do for you.

Questions? Contact BridgeHealth at 1.800.680.1366 to speak with a Care Coordinator and explore what the BridgeHealth Surgery Benefit can do for you.
Using your medical benefits

Save when you see network providers

Your plan offers a provider network of doctors and other healthcare professionals who have agreed to accept lower amounts than their standard charges, just for members of this plan. These lower amounts are negotiated and predetermined. That means when you see a network provider, your share of costs is based on a lower charge—so your costs are lower, too. Network providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that Meritain Health can support your efforts to stay well and have a healthy lifestyle—or to get care as simply as possible when you’re sick.

Remember: If you go outside the network, you still have benefits, but your share of costs will be higher, and the amount you pay will not be based on a lower rate.

Re-claiming your time

With some health plans, paperwork can put you over the edge. Time-consuming and complicated, claim forms rob you of precious time and the balance you seek. That’s why Meritain Health network providers file your claims for you. Pay your copay (if applicable), and you’re on your way!

Helpful tip

You can realize savings while on the road to meeting your annual deductible when you visit doctors and facilities within your provider network.

No referrals

You don’t have to choose a primary care doctor to direct all of your care or to provide referrals to specialists, but Meritain Health recommends that you build a relationship with a “home base” doctor—one who has all of your records and health history. For best benefits, see specialists that are in the network (called in-network or participating providers). Remember, if you see providers outside the network, you’ll share more of the cost.

When it’s an emergency

If you can’t see a network provider in an emergency, don’t worry! Your plan will cover out-of-network emergency charges at the in-network level. For more information, refer to your summary plan description.

Helpful tip

It’s important to know what is covered under your health plan. This can help you to plan for the cost of your healthcare expenditures. Refer to your summary plan description for more information.
Healthcare for you and your family

When sickness or injury throw you off balance

Knowing that you’re in good hands when you’re sick is one of the most comforting feelings there is. You can be assured that your health plan has everything you’ll need to get the right care when something goes wrong.

Remember this: Meritain Health is only a phone call away. If you have questions about your provider network, benefits, deductibles or claims, just give us a call.

Balancing healthcare costs—what you pay and what the plan pays

The Summary of Benefits in the appendix of this packet shows how much you pay for care, and how much the plan pays. It’s a listing of what is and isn’t included in your benefits plan. For more detailed information, see your summary plan description.

After you pay your annual deductible and any up-front copays, the plan begins to pay a percentage of your provider’s charges, for example 90 percent. The remaining percentage, for example 10 percent, is your responsibility—your out-of-pocket costs. You’re protected from financial hardship by a maximum out-of-pocket amount each year—the most you’ll have to pay before the plan covers costs at 100 percent.

Preventive Care:

<table>
<thead>
<tr>
<th></th>
<th>Plan I</th>
<th>Plan II</th>
<th>Plan III</th>
<th>Plan IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical exams</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Well-Child Care</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Mammogram</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Pap smears</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Prostate blood test</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Fecal occult screening</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Medical benefits at-a-glance:

<table>
<thead>
<tr>
<th></th>
<th>Plan I</th>
<th>Plan II</th>
<th>Plan III</th>
<th>Plan IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (Ded)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per individual</td>
<td>$75</td>
<td>$75</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Per family**</td>
<td>$225</td>
<td>$225</td>
<td>$625</td>
<td>$625</td>
</tr>
<tr>
<td>Plan payment</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per individual</td>
<td>$195</td>
<td>$0</td>
<td>$195</td>
<td>$0</td>
</tr>
<tr>
<td>Per family (each covered person)</td>
<td>$195</td>
<td>$0</td>
<td>$195</td>
<td>$0</td>
</tr>
</tbody>
</table>

**The entire family Deductible must be met before any benefits will be paid by the plan. Individual deductibles do not apply to family coverage.
Support for your health journey

Your employer wants you to get the best, most appropriate care, when and where you need it. That’s why your plan includes the extra expertise of Meritain Health’s Medical Management program. The medical management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Before you get care, call medical management

To keep your benefits at the highest level, be sure to call medical management before any of these situations:

- Admission to the hospital for elective or non-emergency care. Notify Meritain Health Medical Management at least ten business days, or as soon as possible, before nonemergency hospitalization to obtain certification of medical necessity for the admission, including the number of days of hospital confinement.
- Additional hospital days. If your doctor believes that it is necessary for you to stay in the hospital longer than the number of days that were originally certified, notify Meritain Health Medical Management again to obtain certification for additional days.
- Emergency admissions. When you are admitted to any hospital on an emergency basis, notify Meritain Health Medical Management within two business days after admission (or as soon as possible after admission) to obtain certification, including the number of days of hospital confinement.
- Purchase of durable medical equipment costing $1,000 or more.
- Outpatient surgeries.
- Home health nursing, including the associated physical therapy and occupational therapy.
- Hyperbaric oxygen treatments.
- Diagnostic radiology (excluding x-rays) CT, MRI, MRA and PET scans.
- Skilled nursing facility services.

Medical management nurses

Our medical management nurses focus on:

- The recommended treatment for your health condition.
- The proposed location of your treatment.
- The proposed length of stay at that location.
- The cost-effectiveness of your treatment and setting.

Note: You and your doctor always have the right to appeal a decision made by the medical management team if you disagree with their decision. A panel of doctors will review the appeal.

Improve your overall health with dental benefits

It’s amazing how important your oral health can be to your body’s total balance and wholeness. Did you know that good dental care not only helps to prevent periodontal disease, but can also add as many as six years onto your life? That’s just one of the reasons why this plan includes dental care benefits for you and your enrolled dependents. Regular check-ups can keep your smiles bright and beautiful.

Dental plan deductibles and plan maximum

All Plans

<table>
<thead>
<tr>
<th>Dental Plan</th>
<th>Deductible per individual</th>
<th>Annual maximum*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I &amp; III</td>
<td>$0</td>
<td>$2,000</td>
</tr>
<tr>
<td>II &amp; IV</td>
<td>$0</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

Covered dental services

<table>
<thead>
<tr>
<th>Service</th>
<th>Plan payment</th>
<th>Dental plans I &amp; III</th>
<th>Dental plans II &amp; IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive and diagnostic</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Basic restorative</td>
<td>80%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Major restorative</td>
<td>50%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Vision care—part of any balanced healthcare picture

To lead your busy life, you need to protect your vision, so your benefit plan includes eye care. Visit any vision care provider and pay for your care at the time you receive it. Then download a claim form at www.meritain.com and send the completed claim to Meritain Health at the address shown on your ID Card. You’ll be reimbursed for the covered services shown below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Plan I &amp; III</th>
<th>Plan II &amp; IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>One eye exam per person per calendar year</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Lenses*</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>One set per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>90% up to $100</td>
<td>90% up to $100</td>
</tr>
<tr>
<td>Contact lenses*</td>
<td>90% up to $200</td>
<td>100% up to $200</td>
</tr>
</tbody>
</table>

*One set of eyeglass lenses, or one 12-month supply of contact lenses, per calendar year

The Performance Drug List

Also called a formulary, the Performance Drug List is created by pharmacy experts and lists FDA-approved, safe, effective and economical drugs.

How the Performance Drug List works:
- Drugs are added to the list on a quarterly basis.
- Brand-name drugs can be removed at the end of the calendar year.
- Every January, the list is updated and available.
- If a generic becomes available, the brand-name drug will become a non-preferred drug, and may only be available for a higher copay.
- When a generic drug becomes available, you’ll pay the lowest copay if you choose the generic.

Why generics make sense

Because companies that develop new drugs have long-term patent protection for their products, other drug companies are prevented by law from manufacturing those drugs—even if they can produce them less expensively.

When patents expire, other companies can make equivalent drugs, usually at a much lower price. Generic equivalents go through rigorous FDA testing regularly to assure that they are just as effective as the brand-name drugs.

Consider all of the compelling reasons to protect your pocketbook with the lower-price generic drugs:
- Generics can cost up to 75 percent less than their brand-name equivalents.
- FDA testing is exactly the same for generic and brand-name drugs.
- Generics contain the same active ingredients as the original, brand-name drug, in the same amounts and dosages.
- Generic drugs sometimes look different from the original brand-name drug in color or shape, but only because they may have different inactive ingredients that won’t change how the drug works.
- Nearly half of all brand-name drugs have generic equivalents—but you may have to ask for them.
- Generics have the lowest copay under this plan, so you save on every prescription.

Contact Scrip World

You can contact Scrip World customer service by calling 1.877.468.6592

Controlling your prescription copay

To get the most from your benefits plan, it pays to be a wise consumer. In many cases, you can control how much your share of costs will be when you fill a prescription. How? Generic drugs cost less to manufacture and they’re just as effective as the name brands. You’ll save money when you request them because generics have a lower copay than preferred or non-preferred drugs.

Note: To see whether a prescription drug is generic, preferred or non-preferred, check the list in the appendix of this packet.
Easy on your time—three ways to get your prescription drugs

Your plan is designed with your time in mind. Use any of these three prescription options.

At your local pharmacy

When you need a prescription for 30 days or less, have it filled at a participating pharmacy. Just show the pharmacist your Meritain Health ID Card and pay your copay at the time of your purchase. If the pharmacy you choose is not in-network and your plan allows reimbursement for out-of-network pharmacies, you’ll pay the entire cost at the time of purchase, then submit a claim for reimbursement. You’ll receive the same amount that a participating pharmacy would receive, minus your copay.

Helpful tip

Be sure to bring your Meritain Health ID Card with you to the pharmacy when filling prescriptions. This will ensure that you receive your full benefits.

By mail order

If you have a chronic condition and you take medication for it for long periods of time, you may fill a larger quantity prescription all at once. Ask your doctor to write two prescriptions—one for 30 days, and one for 90 days. Fill the 30-day prescription at a network pharmacy. Then complete a mail order form and send it, along with the original 90-day prescription signed by your doctor and your copay, to the address on the form.

Online

You can also fill 90-day prescriptions at www.meritain.com. Again, ask your doctor for two prescriptions. Before you request your prescription online, fill the 30-day order at a network drug store, and send (or ask your doctor to send) the 90-day prescription to the address shown on the website. Simply use a credit card to pay your copay.

Prescriptions and Meritain.com

By logging in to www.meritain.com, you can:

- Order new prescriptions.
- Check the status of your online order.
- Find a nearby network pharmacy.
- Check the price of a drug.
- Research drugs, supplements and vitamins.
- Learn more about your coverage.

Not every drug is covered

The plan does not include benefits for over-the-counter medications or drugs used for cosmetic purposes. There may be other exclusions. Scrip World customer service can help you if you have questions, or refer to your more complete summary plan description.

Certain drugs must be approved

If your prescription is for a very expensive drug, or one that can be easily abused, prior authorization may be required. Trained professionals review these prescriptions for your protection. You may need a new written prescription from your doctor for each refill. For more information, see your summary plan description or contact Scrip World customer service at 1.877.468.6592.

Helpful tip

Be sure to bring your Meritain Health ID Card with you to the pharmacy when filling prescriptions. This will ensure that you receive your full benefits.
Are you ready for a health plan that can help restore balance to your life? It’s simple to enroll—just follow the four steps below. If you have any questions during the enrollment process, check with your benefits administrator. Once you’ve completed Step 4 and you’ve served any waiting period, you’re on your way to a fresh new approach to living your best health.

**Step 1—gather your information**

For a complete, efficient enrollment, you may need some of the following information:

- Spouse’s and children’s birth dates.
- Spouse’s and children’s Social Security Numbers (SSN).
- Date of marriage.
- If your spouse or children are covered under another health plan, the name of the plan or insurance carrier and the effective date of benefits.
- If your benefits will include life insurance, your beneficiaries’ names and SSNs.

**Step 2—double-check every form**

The decisions you make as you enroll in your health plan will affect your future healthcare and finances. We want to help you choose wisely. If you have not yet read the earlier sections of this packet, take time to do it now. Don’t enroll without understanding your options.

Consider:

- Your personal health and the health of your family members.
- Healthcare expenses you can predict for you and your family.
- Other health benefits you or your family members may have.
- Your budget for benefits and expected healthcare services.

**Step 3—make your decision**

It’s time to make changes in the way you think about your health and your healthcare. It’s time to step up, take charge and make the best use of your plan, your money and your time. Are you ready to commit to better health, a better life—and the balance you want? Meritain Health is ready and committed to helping you.

**Enrollment tips**

Before you enroll, remember:

- Copays and deductibles are out-of-pocket costs you will pay for doctor visits and other medical services.
- If you or any dependent(s) are covered by another health plan, you have several options.
- If you decline benefits now, you won’t be able to enroll later unless a special enrollment situation occurs, or during an open enrollment period.

**Step 4—Complete your enrollment, and you’re on your way!**

All eligible employees must complete the enrollment form, whether you’re choosing this plan or declining benefits. Your enrollment form is included in the back of this packet.

Complete, sign and return your enrollment form to your employer within 31 days of your eligibility date whether you’re enrolling or declining benefits.

- **Write clearly**
  If your form is unreadable, your enrollment may be delayed, or incorrect.
- **Don’t forget the back side**
  Missing or incomplete information will delay your enrollment.
- **Sign and date your enrollment form**
  Remember to sign and date the form, even if you’re declining benefits.
The final step toward better balance and better living

After you’ve completed enrollment, your employer has approved it, and after any waiting period has passed, your benefits will be effective.

Your Meritain Health ID Card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you.

Sample ID Card

Need to fill a prescription before you receive your ID Card?

- Your healthcare plan includes a network of providers you can visit for healthcare services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents’ benefits.
- Your pharmacy coverage information is listed on the front of your card, and includes the Scrip World customer service number.
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- Your pharmacy information is listed on the front of your card, and includes the Scrip World customer service number.

Not to worry—if you need to see your doctor but you don’t have your ID Card yet, just tell the clinic staff that you’re a member of this plan. The clinic will contact Meritain Health Customer Service to verify your benefits.

If you need a prescription before you get your new Meritain Health ID Card, just pay for your prescription and send Express Scripts a completed prescription drug claim form (see the appendix for a copy). Send your receipt and the completed claim form to the address shown on the form and you’ll be reimbursed up to plan limits, minus any copay.

You or your pharmacist may contact Scrip World Customer Service at 1.877.468.6592 with any questions.

Lost ID Card?

Contact Meritain Health at 1.866.808.2609, or visit www.meritain.com to order new cards.
Glossary of terms

Ambulatory surgery
Surgery performed at an ambulatory surgical facility (a licensed public or private facility), which does not provide services or accommodations for a patient to stay overnight.

Copay
An amount of money that a participant is required to pay each time he or she visits a healthcare provider or fills a prescription.

Deductible
The annual out-of-pocket amount that a plan participant is responsible for paying before the health plan covers his or her medical costs according to the terms of the plan. Until a person meets the annual deductible, he or she pays the full cost of healthcare services received, unless the service is not subject to the annual deductible as stated in the benefit schedule.

Meritain Health Member Portal
Your online health information portal and your personal connection to your plan. Here you can order prescriptions, find healthcare providers, research health topics and get answers to your questions about healthcare. The personal information used to access www.meritain.com is confidential. You may need the information on your ID Card to log in for the first time.

Provider network
Organization that negotiates special, lower rates for healthcare services provided by physicians and other care providers who are within the network. Providers who belong to a network are called participating or in-network providers.

Usual and customary charge
Your plan reimburses charges from non-participating or out-of-network providers that are equal to, or less than, usual and customary charges. Usual and customary charges are the amounts most frequently charged for the same service:

- In the same geographic area; and
- By other providers in the same or similar medical area.

The fees charged by non-participating providers may exceed the usual and customary charges recognized by your plan. In such cases, Meritain Health will process an amount equal to the usual and customary charge for the healthcare service you received, and you will be reimbursed for a portion of that amount according to your plan’s out-of-network benefits.
## Important Contact Information

<table>
<thead>
<tr>
<th>What do you need help with?</th>
<th>Who to contact</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating providers</td>
<td>Aetna provider line</td>
<td>1.800.343.3140</td>
<td><a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a></td>
</tr>
<tr>
<td></td>
<td>TAPPN</td>
<td></td>
<td><a href="http://www.tappn.com">www.tappn.com</a></td>
</tr>
<tr>
<td>My prescription drug benefits</td>
<td>Scrip World, powered by Express Scripts Customer Service</td>
<td>1.877.468.6592</td>
<td></td>
</tr>
<tr>
<td>Precertification</td>
<td>Meritain Health Medical Management</td>
<td>1.800.242.1199</td>
<td></td>
</tr>
<tr>
<td>Planned Surgeries</td>
<td>Bridgehealth</td>
<td>1.800.680.1366</td>
<td></td>
</tr>
<tr>
<td>24-hour access to registered nurses</td>
<td>24x7 Nurse Line</td>
<td>1.866.726.6529</td>
<td></td>
</tr>
<tr>
<td>Enrollment or benefit elections</td>
<td>Bering Strait human resources representative</td>
<td>1.907.624.3611</td>
<td></td>
</tr>
</tbody>
</table>
### Summary of Benefits

<table>
<thead>
<tr>
<th>Deductible, per Calendar Year</th>
<th>Plan I</th>
<th>Plan II</th>
<th>Plan III</th>
<th>Plan IV*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$75</td>
<td>$75</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Family</td>
<td>$225</td>
<td>$225</td>
<td>$625</td>
<td>$625</td>
</tr>
<tr>
<td>Transplant Deductible - Failure to Pre-authorize</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

* Plans II and IV are designated for Administrative Level Employees and Dual Covered Employees. In place of 2 Explanation of Benefits (EOBs) being issued due to Coordination of Benefits, one EOB will be issued for the Primary Employee, which will provide coverage at 100% of the U&C allowed amount.

** The entire family Deductible must be met before any benefits will be paid by the Plan. Individual Deductibles do not apply to family coverage

### Pre-certification Penalty

<table>
<thead>
<tr>
<th></th>
<th>Plan I</th>
<th>Plan II</th>
<th>Plan III</th>
<th>Plan IV*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-certification Penalty</td>
<td>$750</td>
<td>$750</td>
<td>$750</td>
<td>$750</td>
</tr>
</tbody>
</table>

Pre-certification is required for all Hospital confinements as well as for certain Outpatient services. Refer to the “Special Features of Your Plan” section of this Summary Plan Description for a complete listing of these Outpatient services.

Also, referrals by Indian Health Services (“IHS”) to non-native Hospitals or medical facilities for any treatment or services not provided by IHS must be pre-certified.

### Out-of-Pocket Maximum Expense (Excluding Deductible), per Calendar Year

<table>
<thead>
<tr>
<th></th>
<th>Plan I</th>
<th>Plan II</th>
<th>Plan III</th>
<th>Plan IV*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$195</td>
<td>$0</td>
<td>$195</td>
<td>$0</td>
</tr>
<tr>
<td>Family (Each Covered Person)</td>
<td>$195</td>
<td>$0</td>
<td>$195</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Lifetime Maximums

<table>
<thead>
<tr>
<th></th>
<th>PPO and Non-PPO (combined)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Plan</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Organ and Bone Marrow Transplant</strong></td>
<td>1 Transplant</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>60 visits</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>90 days</td>
</tr>
<tr>
<td><strong>Speech/Pathology Therapy</strong></td>
<td>60 visits</td>
</tr>
<tr>
<td><strong>Spinal Manipulations</strong></td>
<td>20 visits</td>
</tr>
<tr>
<td><strong>Hearing Aid</strong></td>
<td>One</td>
</tr>
<tr>
<td><strong>Preventive Care (Deductible Waived)</strong></td>
<td>One</td>
</tr>
<tr>
<td>Covered exams are limited per Calendar Year to:</td>
<td>One</td>
</tr>
<tr>
<td>Routine PAP, including lab and office visit</td>
<td>One</td>
</tr>
<tr>
<td>Routine physical exam, including diagnostic tests</td>
<td>One</td>
</tr>
<tr>
<td>Routine prostate exam, including PSA test</td>
<td>One</td>
</tr>
<tr>
<td>Routine colonoscopy (per five Calendar Years)</td>
<td>One</td>
</tr>
<tr>
<td>Routine Immunizations</td>
<td>One</td>
</tr>
<tr>
<td>Mammograms (Routine or Medically Necessary) (Deductible Waived)</td>
<td>100%</td>
</tr>
<tr>
<td>Routine limited per Calendar Year to:</td>
<td>One</td>
</tr>
<tr>
<td>Preventive Well Baby/Child Care (Deductible Waived)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Hospital Charges - Anchorage Facilities</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td>PPO Facility</td>
<td>90%</td>
</tr>
<tr>
<td>Non-PPO Facility (see note below)*</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Hospital Charges - Outside Anchorage</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td>PPO Facility</td>
<td>90%</td>
</tr>
<tr>
<td>Non-PPO Facility</td>
<td>90%</td>
</tr>
</tbody>
</table>

*Out-of-Pocket Expense payments to non-preferred Anchorage Hospitals will NOT accrue towards the Calendar Year Out-of-Pocket Maximum Expense limits.

Pre-certification is required for each admission. Penalties do not accrue toward your Out-of-Pocket Maximum Expense limit.

### Certain surgical procedures are covered at 100% (deductible waived) when they are received through the BridgeHealth Surgery Benefit Option. Not all surgical procedures are eligible for coverage under this option. Please refer to the BridgeHealth Surgery Benefit Option for a more detailed description of this benefit.

<table>
<thead>
<tr>
<th></th>
<th>Plan I</th>
<th>Plan II</th>
<th>Plan III</th>
<th>Plan IV*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Facility</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Room &amp; Board Limit</td>
<td>Semi-Private Room Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Speech/Pathology Therapy</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Private Duty Nursing Care</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (not for Custodial Care)</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Durable Medical Equipment &amp; Medical Supplies</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Admission Tests within 7 days of Hospital Admission (Deductible Waived)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Disorders and Substance Use Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Inpatient &amp; Outpatient - Anchorage Facilities</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>PPO Facility</td>
<td>60%</td>
<td>100%</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>Non-PPO Facility</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient &amp; Outpatient - Outside Anchorage</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>PPO Facility</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Care (Ambulance and Emergency Room)</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Pre-certification is required for each admission. Penalties do not accrue toward your Out-of-Pocket Maximum Expense limit.

Newborn Care 90% 100% 90% 100%

Hospital Newborn nursery care is covered. This includes Physician Inpatient Newborn examinations and circumcision during the initial Hospital confinement of the Newborn at birth.

All other Covered Services 90% 100% 90% 100%

Prescription Drug Benefits

Pharmacy Option (180-day supply): (Not Subject to Deductible)

Copayment, per prescription or refill 10%

Mail Order Option (180-day supply): (Not Subject to Deductible)

Copayment, per prescription or refill 10%

Non-Participating Pharmacy Benefit (When you do not use your Retail Pharmacy Card)

Prescriptions dispensed by non-participating pharmacies are covered under the Major Medical Benefits of the Plan, subject to the Calendar Year Deductible, and paid based on the Benefit Percentage in the Schedule of Benefits. The balance of the Benefit Percentage amount paid by the Covered Person will accrue toward the Out-of-Pocket Calendar Year Maximum. These claims should be submitted directly to Meritain Health.

Plans I & III

<table>
<thead>
<tr>
<th>Annual Deductible Amount</th>
<th>Plans I &amp; III</th>
<th>Plans II &amp; IV*</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Benefit Percentages:

Preventive 100% 100%

Basic Restorative 80% 100%

Major 50% 100%

Calendar Year Maximum benefits (per Covered Person):

Diagnostic & Preventive, Basic and Major $2,000 $2,000

Vision Benefits

<table>
<thead>
<tr>
<th>Examination</th>
<th>Plans I &amp; III</th>
<th>Plans II &amp; IV*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses</td>
<td>90% of U&amp;C</td>
<td>100% of U&amp;C</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>90% up to $100</td>
<td>100% up to $100</td>
</tr>
</tbody>
</table>

Calendar Year Maximums

One complete eye exam per Covered Person per Calendar Year

One set of eyeglass lenses, or one 12-month supply of contact lenses, per Calendar Year

One set of frames per Covered Person every Calendar Year
Your BridgeHealth Surgery Benefit™

Your plan includes the BridgeHealth Surgery Benefit

The BridgeHealth Surgery Benefit, gives you access to:
- Centers of Excellence for major planned surgeries and procedures.
- Coverage for travel costs for you and a companion.
- Provisions to eliminate your out-of-pocket costs.
- A dedicated Care Coordinator who provides service and support.

The program includes coverage for:
- Cardiac procedures
- Spine surgeries
- Vascular surgeries
- Specific cancer treatments (only surgical tumor removal)
- Orthopedic surgeries
- Other planned surgeries

Dedicated Care Coordination

Your BridgeHealth Care Coordinator will work with you to:
- Review all options available under the BridgeHealth Surgery Benefit.
- Transfer your medical records for initial review.
- Provide detailed information about BridgeHealth providers, including education and experience.
- Satisfy all health plan requirements regarding medical necessity review and precertification.
- Schedule travel and lodging for you and a companion, including meal and incidental allowances.

Customer testimonials

Carole, Fairbanks resident
“Traveling ‘outside’ for medical care in an unfamiliar city, with an unknown doctor, and no family close by can be a very scary situation. BridgeHealth makes it easy and expertly calms your fears...You don’t have to think of anything. They are wonderful to work with! I could not have asked for anything better. There were no problems (none!) from start to finish.”

Sindy, Fairbanks resident
“I needed to have my lower back fused. My health coordinator did her research and sent me information on three facilities and the surgeons at each one. I was able to study each surgeon, their schooling, background, experience, along with the national ratings on each hospital. I never once had to pick up the phone and plan or book anything. It’s been almost one year since the surgery and I’m doing great, and what’s even better, I don’t have one medical bill from the surgery.”

How can I take advantage of the BridgeHealth Surgery Benefit?

Simply call BridgeHealth at 1.800.680.1366 to speak with a Care Coordinator and explore what the BridgeHealth Surgery Benefit can do for you. You’ll need to provide your member ID (which can be found on your member ID Card), your date of birth, and any information you’ve received related to your procedure—including any relevant medical records, such as reports and x-rays.

You can also visit BridgeHealth online at www.BridgeHealthMedical.com.
Your 24x7 Nurse Line

What is the 24x7 Nurse Line?

You can reach the Meritain Health Nurse Line 24 hours a day, seven days a week for your health-related questions.

You and your family can get health information or medical advice. You can also talk directly with a Registered Nurse (RN), or listen to recorded health topics. The RN can help you choose the best care for you, or suggest self-care techniques or over-the-counter medication.

How does the 24x7 Nurse Line work?

Speak with an RN.

The 24x7 Nurse Line is staffed by specially trained RNs who can answer your questions about a current illness, discuss alternative treatments for health conditions, and help you make healthy lifestyle choices.

Use the improved Health Information Library.

When you visit the recently enhanced Health Information Library, you can find over 1,000 health and wellness topics using voice activation! Simply state the topic you’d like to learn about, and you’ll hear a recorded message on the topic you have chosen.

When should I call?

You can call the 24x7 Nurse Line any time you have a question. The RNs can answer questions like:

- “It’s 2:00 a.m. and my son has a high fever and a sore throat. Should I take him to the emergency room?”
- “I just sprained my wrist. Should I have an X-ray?”
- “I’ve heard about a new drug for weight loss. Could it help me?”
- “My doctor said I need to have surgery. What are my alternatives?”

You can speak with an RN by calling the 24x7 Nurse Line at 1.866.726.6529.

If you have any questions, just call Meritain Health using the phone number on your member ID Card.
**COMPANY NAME:** Bering Strait School District  
**GROUP #:** AK035

---

**BENEFIT ENROLLMENT FORM**

---

**EMPLOYER INFORMATION**

- **LAST NAME:**  
- **FIRST NAME:**  
- **MI:**  
- **SOCIAL SECURITY NO.:**  
- **DATE OF BIRTH (MM/DD/YY):**  
- **GENDER:**  
- **MARITAL STATUS:**  
- **MAILING ADDRESS:**  
- **CITY:**  
- **STATE:**  
- **ZIP:**  
- **HOME PHONE NUMBER:**  
- **WORK PHONE NUMBER:**

**ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE?**
- YES  
- NO  

**IF YES, NAME OF INSURANCE:**

**EFFECTIVE DATE:**

**TYPE OF POLICY (Retiree, COBRA, Spouse):**

**POLICY HOLDER (Self, Spouse):**

**IF ENROLLED IN MEDICARE:**
- **EFFECTIVE DATE:**
- **PART A:**
- **PART B:**
- **HICN:**

**ENTITLEMENT TO MEDICARE DUE TO:**
- **AGE**  
- **DISABILITY**  
- **END STAGE RENAL DISEASE (ESRD)**

---

**BENEFIT SELECTION**

- **COVERAGE TYPE:**
  - **LIFE/A&D&D**
  - **MEDICAL**
  - **DENTAL**
  - **VISION**

- **PLAN ELECTED (IF APPLICABLE):**
  - **PPO (IF APPLICABLE):**

- **COVERAGE LEVEL:**
  - **LIFE/A&D&D**
  - **MEDICAL**
  - **DENTAL**
  - **VISION**
  - **SINGLE**
  - **EMPLOYEE + SPouse**
  - **EMPLOYEE + CHILD**
  - **FAMILY**
  - **DECLINE**

---

**BENEFICIARY DESIGNATION**

**PRIMARY BENEFICIARY**
- **NAME:**
- **RELATIONSHIP:**
- **SS#:**
- **PERCENTAGE:**

**SECONDARY BENEFICIARY**
- **NAME:**
- **RELATIONSHIP:**
- **SS#:**
- **PERCENTAGE:**

---

**DEPENDENT INFORMATION**

**DEPENDENT FULL NAME (REQUIRED)**  
**LAST, FIRST, MIDDLE**

<table>
<thead>
<tr>
<th>DEPENDENT FULL NAME</th>
<th>SOCIAL SECURITY NO.</th>
<th>RELATIONSHIP</th>
<th>DATE OF BIRTH (MM/DD/YY)</th>
<th>GENDER</th>
<th>CHECK COVERAGE</th>
<th>DISABLED DEPENDENT*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MEDICAL</td>
<td>YES/NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DENTAL</td>
<td>YES/NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>VISION</td>
<td>YES/NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MEDICAL</td>
<td>YES/NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DENTAL</td>
<td>YES/NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>VISION</td>
<td>YES/NO</td>
</tr>
</tbody>
</table>

---

**DISCLAIMER:** If your child is mentally or physically disabled, please provide appropriate documentation.

---

**EMPLOYER USE ONLY**

- **DATE OF HIRE:**
- **EFFECTIVE DATE:**
- **DIVISION #:**
- **DEPT. #: / CLOCK #:**
- **ANNUAL SALARY:**
- **HOURLY**
- **SALARY**
- **NEW ENROLLMENT**
  - **Active**
  - **Retiree**
  - **Full Time**
  - **Part Time**
  - **COBRA**
- **ENROLLMENT CHANGE**
  - **Marriage**
  - **Birth**
  - **Adoption**
  - **Reinstatement**
  - **Loss of Coverage**
  - **Other:**

**Employer Representative Signature:**

**Date:**

 THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM

(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

---

**THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES**

---

**PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM**

(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

---

**EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED**

---

**LAST NAME**

---

**FIRST NAME**

---

**MI**

---

**SOCIAL SECURITY NO.**

---

**DATE OF BIRTH (MM/DD/YY):**

---

**GENDER:**

---

**MARITAL STATUS:**

---

**MAILING ADDRESS:**

---

**CITY:**

---

**STATE:**

---

**ZIP:**

---

**HOME PHONE NUMBER:**

---

**WORK PHONE NUMBER:**

---

**ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE?**

---

**IF YES, NAME OF INSURANCE:**

---

**EFFECTIVE DATE:**

---

**TYPE OF POLICY (Retiree, COBRA, Spouse):**

---

**POLICY HOLDER (Self, Spouse):**

---

**IF ENROLLED IN MEDICARE:**

---

**EFFECTIVE DATE:**

---

**PART A:**

---

**PART B:**

---

**HICN:**

---

**ENTITLEMENT TO MEDICARE DUE TO:**

---

**AGE**

---

**DISABILITY**

---

**END STAGE RENAL DISEASE (ESRD)**

---

**BENEFIT SELECTION**

---

**COVERAGE TYPE:**

---

**PLAN ELECTED (IF APPLICABLE):**

---

**PPO (IF APPLICABLE):**

---

**COVERAGE LEVEL:**

---

**LIFE/A&D&D**

---

**MEDICAL**

---

**DENTAL**

---

**VISION**

---

**SINGLE**

---

**EMPLOYEE + SPouse**

---

**EMPLOYEE + CHILD**

---

**FAMILY**

---

**DECLINE**

---

**BENEFICIARY DESIGNATION**

---

**PRIMARY BENEFICIARY**

---

**NAME:**

---

**RELATIONSHIP:**

---

**SS#:**

---

**PERCENTAGE:**

---

**SECONDARY BENEFICIARY**

---

**NAME:**

---

**RELATIONSHIP:**

---

**SS#:**

---

**PERCENTAGE:**

---

**DEPENDENT INFORMATION**

---

**DEPENDENT FULL NAME (REQUIRED)**

---

**LAST, FIRST, MIDDLE**

---

**SOCIAL SECURITY NO. (REQUIRED):**

---

**RELATIONSHIP (REQUIRED):**

---

**DATE OF BIRTH (MM/DD/YY):**

---

**GENDER (M/F):**

---

**CHECK COVERAGE**

---

**DISABLED DEPENDENT*"**

---

"*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION."
**COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS**

<table>
<thead>
<tr>
<th>IS YOUR SPOUSE EMPLOYED?</th>
<th>YES</th>
<th>NO</th>
<th>IF YES, FULL TIME</th>
<th>PART TIME</th>
<th>SPOUSE EMPLOYER NAME:</th>
<th>SPOUSE DATE OF BIRTH:</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS ENROLLED IN WITH HIS/HER EMPLOYER**

<table>
<thead>
<tr>
<th>TYPE OF OTHER COVERAGE</th>
<th>CARRIER NAME</th>
<th>CARRIER ADDRESS</th>
<th>EFFECTIVE DATE (MM/DD/YYYY)</th>
<th>TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)</th>
<th>LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS**

<table>
<thead>
<tr>
<th>ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**LIST ALL FAMILY MEMBERS ENROLLED**

<table>
<thead>
<tr>
<th>TYPE OF OTHER COVERAGE</th>
<th>CARRIER NAME</th>
<th>CARRIER ADDRESS</th>
<th>EFFECTIVE DATE (MM/DD/YYYY)</th>
<th>TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)</th>
<th>COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DEGREE, QMCSO)*</th>
<th>LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID, TRICARE, MICHILD, ETC.)**

<table>
<thead>
<tr>
<th>IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE?</th>
<th>YES</th>
<th>NO</th>
<th>IF YES, PLEASE COMPLETE BELOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**LIST ALL FAMILY MEMBERS ENROLLED**

<table>
<thead>
<tr>
<th>TYPE OF COVERAGE</th>
<th>EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE</th>
<th>PART B EFFECTIVE DATE (IF APPLICABLE)</th>
<th>HICN</th>
<th>IS MEDICARE COVERAGE DUE TO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**PLAN DECLARATION**

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a 'status change', as defined under the Plan, and if my change in elections is consistent with that 'status change', (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions. If any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above. I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

**NOTICE OF SPECIAL ENROLLMENT PERIODS**

If you are declining enrollment in the Plan’s health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan’s health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources representative.

**SIGNATURE AND AUTHORIZATION**

<table>
<thead>
<tr>
<th>EMPLOYEE SIGNATURE</th>
<th>PRINT EMPLOYEE NAME</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

173.7292015
**Health Claim Form**

**Important:** Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers’ Compensation Carrier/Administrator for proper instructions regarding a work-related claim.

### Section 1. Employee Information

<table>
<thead>
<tr>
<th>Name (last, first, initial)</th>
<th>Sex</th>
<th>Employer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>Identification Number</td>
<td>Birthdate</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

### Section 2. Patient Information

- **The patient is:**
  - [ ] The employee (Go to section 3)
  - [ ] Employee’s Spouse (Complete spouse information)
  - [ ] Employee’s Child (Complete spouse and child information)

<table>
<thead>
<tr>
<th>Spouse’s Name (last, first, initial)</th>
<th>Sex</th>
<th>Child’s Name (first, last, initial)</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse’s Birthdate</td>
<td>Spouse’s Social Security Number</td>
<td>Child’s Birthdate</td>
<td>Child’s Social Security Number</td>
</tr>
<tr>
<td>Spouse’s Employer</td>
<td>Spouse’s Employer’s Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 3. Other Coverage

- [ ] Yes (then complete)  
- [ ] No (go to section 4)  

<table>
<thead>
<tr>
<th>Name of Policy Holder:</th>
<th>Name of Other Health Insurance Carrier or Plan</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Insurance Carrier’s or Plan’s Telephone #</td>
<td>Type of Coverage</td>
<td>Group</td>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse’s Employer</td>
<td>Spouse’s Employer’s Address</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Section 4. About This Claim

- [ ] Injury  
- [ ] Illness

Describe injury, when and how it happened or nature of illness:

Was this injury the result of an accident?  
- [ ] Yes  
- [ ] No

If auto insurance was involved, please provide:

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Name of insurance company</th>
<th>Address (city, state, zip)</th>
</tr>
</thead>
</table>

Was this a work-related injury?  
- [ ] Yes  
- [ ] No

If injury is work-related, please contact the Workers’ Compensation Carrier/Administrator for proper instructions regarding this claim.

**Employee’s (or adult dependent’s) Signature Required**

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature: Date:

**Assignment of Benefits** (complete this section if provider is to be paid directly)

I authorize payment of benefits to the doctor or supplier of services listed here.

<table>
<thead>
<tr>
<th>Provider to be paid</th>
<th>Employee’s Signature</th>
</tr>
</thead>
</table>

Provider’s tax ID number or Social Security Number Date
**IMPORTANT:** Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill.

| A | Patient Name (last, first, initial) | Birthdate |
| B | Address |
| C | Is this condition the result of an injury arising from patient’s employment? [ ] Yes [ ] No |
|   | If yes, please contact the Worker's Compensation Carrier/Administrator for proper instruction regarding this claim. |
| D | Pregnancy? [ ] Yes [ ] No |
|   | If yes, expected date of delivery |
| E | If illness, date of first treatment |
|   | If treating injury, date of injury |
| F | Name of referring physician |
|   | Referring physician’s address |
| G | Name and facility where services were rendered (if other than home or office) |
| H | Was laboratory work performed outside your office? [ ] Yes [ ] No |
| I | For service related to hospitalization, give dates: |
|   | ☐ Admitted ☐ Discharged |
| J | Diagnosis and current conditions (if diagnosis other than ICD-10* used, give name): |
|   | 1. |
|   | 2. |
|   | 3. |
|   | 4. |
| K | Dates of Service From To |
|   | Places of Services** |
|   | Procedure Code (If other than CPT*** code used, give name) |
|   | Description of surgical or medical services rendered |
|   | Diagnosis Code |
|   | Charges |

*ICD-10 * International Classification of Disease  
**Abbreviations:  
11-Physician’s Office  
12-Patient’s Home  
12-Inpatient Hospital  
22-Outpatient Hospital  
23-Emergency Room  
81-Independent Laboratory

Date   Physician’s Name (print)   Degree   Provider’s Tax ID Number or Social Security Number:  
Must be furnished under authority of law

Physician’s Signature   Telephone ( )   Street Address   City   State   Zip Code

**STATUS AND BENEFIT INFORMATION:**  
1.866.808.2609

Send to:  
Meritain Health  
P.O. Box 853921  
Richardson, TX 75085-3921  
Fax: 1.763.852.5057
ADA American Dental Association® Dental Claim Form

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes)
   □ Statement of Actual Services □ Request for Predetermination/Preauthorization
   □ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)
4. Dental? □ Medical? □ (If both, complete 5-11 for dental only)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient’s Relationship to Person named in #5

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

<table>
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<tr>
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</tbody>
</table>

34a. Diagnosis Code(s) (Primary diagnosis in “A”)

<table>
<thead>
<tr>
<th>32. Total Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789 1 0 1 1 1 2 1 3 1 4 1 5 1 6 34a. Diagnosis Code(s) (Primary diagnosis in “A”)</td>
</tr>
</tbody>
</table>

35. Remarks

AUTHORIZATIONS
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Use “Place of Service Codes for Professional Claims”)
   □ e.g. 11=office; 22=HIP Hospital
39. Enclosures (Y or N)
   □ Yes (Complete 41-42)
   □ No (Skip 41-42)

40. Is Treatment for Orthodontics?
   □ Yes (Complete 41-42)

41. Date of Accident (MM/DD/CCYY)

42. Months of Treatment
   □ Yes (Complete 44)

43. Replacement of Prosthesis
   □ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/YYYY)

45. Treatment Resulting from
   □ Occupational Illness/Injury
   □ Auto accident
   □ Other accident

46. Date of Accident (MM/DD/YYYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

57. Additional Provider ID

58. Provider Specialty Code

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To reorder call 800.947.4746
or go online at adacatalog.org
The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA’s web site (ADA.org).

**GENERAL INSTRUCTIONS**
A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the ‘tick-marks’ printed in the margin.
B. Complete all items unless noted otherwise on the form or in the CDT manual’s instructions.
C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
D. All dates must include the four-digit year.
E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

**COORDINATION OF BENEFITS (COB)**
When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer’s Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the “Remarks” field (Item 35). There are additional detailed completion instructions in the CDT manual.

**DIAGNOSIS CODING**
The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient’s oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer (“A” through “D” as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter “A”)

**PLACE OF TREATMENT**
Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at “www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf”

**PROVIDER SPECIALTY**
This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as “Dentist” may be used instead of any of the other codes.

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>122300000X</td>
</tr>
<tr>
<td></td>
<td>A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.</td>
</tr>
<tr>
<td>General Practice</td>
<td>1223G0001X</td>
</tr>
<tr>
<td>Dental Specialty (see following list)</td>
<td>Various</td>
</tr>
<tr>
<td>Dental Public Health</td>
<td>1223D0001X</td>
</tr>
<tr>
<td>Endodontics</td>
<td>1223E0200X</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1223X0400X</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>1223P0221X</td>
</tr>
<tr>
<td>Periodontics</td>
<td>1223P0300X</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>1223P0700X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Pathology</td>
<td>1223P0106X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Radiology</td>
<td>1223D0008X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>1223S0112X</td>
</tr>
</tbody>
</table>

Provider taxonomy codes listed above are a subset of the full code set that is posted at “www.wpc-edi.com/codes/taxonomy”
# Vision Claim Form

**For ALL claims, this area must be filled in completely.**

## Employee Information

<table>
<thead>
<tr>
<th>Employee’s Name (last, first, middle initial)</th>
<th>Employee ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Employee’s Date of Birth</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

If the patient is a dependent, please complete ALL of the following. If the patient is the employee, go directly to the area below the shaded box.

## Patient Information

<table>
<thead>
<tr>
<th>Patient’s Name (if other than employee)</th>
<th>Patient’s ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Date of Birth (Month, Day, Year)</td>
<td>Relationship to Employee</td>
</tr>
</tbody>
</table>

Is patient covered by another Employer Group Plan or Retirement Group Plan?  
☐ Yes ☐ No  
(If yes, please complete the two items below)

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Group Number</th>
<th>Name and address of Insurance Company or Organization</th>
</tr>
</thead>
</table>

## Release

Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud, submits an application for coverages, or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.

I hereby authorize payment of these benefits be send directly to:  
☐ Provider of Service ☐ Employee (attach itemized bill or receipt)

<table>
<thead>
<tr>
<th>Patient’s Signature (parent or guardian if claim is on a minor)</th>
<th>Date</th>
</tr>
</thead>
</table>

The below sections are to be completed by the Provider.

## Exam

Indicate the nature of disease, injury or vision disorder | Date of examination | Name of provider performing services |

| Refraction? | Yes ☐ | No ☐ | Contact Lenses? | Yes ☐ | No ☐ |

| Tonometry? | Yes ☐ | No ☐ | Cataract Surgery? | Yes ☐ | No ☐ |

**Examination Charge:** $  
**Amount paid by employee:** $  

<table>
<thead>
<tr>
<th>Signature of provider</th>
<th>Degree/Title</th>
<th>Date</th>
<th>Provider’s Social Security or Tax ID Number (required by law):</th>
</tr>
</thead>
</table>

## Lenses

Date ordered: Date dispensed: ☐ Pair ☐ 1/2 Pair  

<table>
<thead>
<tr>
<th>Date ordered</th>
<th>Date dispensed</th>
<th>Parts</th>
<th>Complete</th>
<th>Partial</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sphere</th>
<th>Cylinder</th>
<th>Axis</th>
<th>Prism</th>
<th>Add</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Lenses Charge:** $  

**Frames**

<table>
<thead>
<tr>
<th>Type Lens</th>
<th>Charge</th>
</tr>
</thead>
</table>

| ☐ Single vision | ☐ bifocal | ☐ trifocal | ☐ Lenticular |
| Contact Lenses |  |  |  |
| Oversized Lenses |  |  |  |
| Sunglasses |  |  |  |
| ☐ Tint # |  |  |  |
| ☐ Photosensitive – i.e. Brown, Gray, etc. |  |  |  |
| ☐ Other |  |  |  |

<table>
<thead>
<tr>
<th>Lens Manufacturer:</th>
<th>Name of provider performing services (please print)</th>
</tr>
</thead>
</table>

**Frame Charge:** $  

<table>
<thead>
<tr>
<th>Date ordered</th>
<th>Date dispensed</th>
<th>Parts</th>
<th>Complete</th>
<th>Partial</th>
</tr>
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</tr>
<tr>
<td>OS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Frames Charge:** $  

**Total Charge:** $  
**Amount paid by employee:** $  

---

**IMPORTANT:** CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED. Do not send this form through your employer. ATTACH PROVIDER BILLING. If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your member ID Card.
Prescription Drug Reimbursement / Coordination of Benefits Claim Form

An incomplete form may delay your reimbursement. See the back for instructions and complete all information.

**Cardholder Information** See your prescription drug ID card.

<table>
<thead>
<tr>
<th>Group No.</th>
<th>Member ID</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member Name First</th>
<th>Last</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**Patient Information**

<table>
<thead>
<tr>
<th>Patient Name First</th>
<th>Last</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Date of Birth (Month/Day/Year)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Relationship to Plan Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pharmacy Information**

<table>
<thead>
<tr>
<th>Name of Pharmacy</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone (include area code)</th>
</tr>
</thead>
</table>

Is this an on-site nursing home pharmacy?  □ Yes  □ No

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Express Scripts or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Pharmacist or Representative (Required) NCPDP/NPI Required

**Claim Receipts**

Tape receipts or itemized bills on the back. See back for details.

Check the appropriate box if any receipts or bills are for a:

- Compound prescription
  - Make sure your pharmacist lists ALL the VALID NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

ONE CLAIM FORM PER COMPOUND SUBMISSION

- Medication purchased outside of the United States
  - Please indicate:
    - Country ___________________________
    - Currency used ______________________

- Allergy medication

**Coordination of Benefits**

(Another Health Plan has paid a portion.) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?  □ Yes  □ No

- Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid (1)
- Card Program (3)
- Express Scripts Mail Order (4)

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.†

Please tape receipts on the back of this page.

**Acknowledgment**

I certify that the medication(s) described was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I certify that the medication(s) described were not for an on-the-job injury. By completing this form, I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.*

X

Signature of Member Date

*If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form.

Please request that your pharmacy contact Pharmacy Services at 800.922.1557 for assistance.
Claim Receipts
Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

**Tape receipt for prescription 1 here.**
**Receipts must contain the following information:**
- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

**Tape receipt for prescription 2 here.**
**Receipts must contain the following information:**
- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

**COMPOUND PRESCRIPTIONS ONLY**

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the “metric quantity” expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

**Instructions Read carefully before completing this form.**

1. Always present your prescription drug ID card at the participating retail pharmacy.
2. Use this form when you have paid full price for a prescription drug at a retail pharmacy or need to submit claims under Coordination of Benefits rules.
3. You must complete a separate claim form for each pharmacy used and for each patient.
4. You must submit claims within 1 year of date of purchase or as required by your plan.
5. Be sure your receipts are complete.
   In order for your request to be processed, all receipts must contain the information listed at the top of this page. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. The plan member should read the acknowledgment carefully, and then sign and date this form.

7. **Return the completed form and receipt(s) to:**
   Express Scripts
   ATTN: Commercial Claims
   P.O. Box 2872
   Clinton, IA 52733-2872

8. You may also **fax your claim form to:** 608.741.5475.
   Please use one claim form per fax.
   Do not combine claims for different members in the same fax submission.

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**Additional Coordination of Benefits Instructions**

**Another Health Plan Paid**

You must first submit the claim to the primary insurance carrier. Once the statement from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided at the top of this page, and attach the statement from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

**Prescription Drug Programs or HMO Plans**

**Retail pharmacies**

If the primary plan is one in which a copayment or coinsurance is paid at a retail pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the copayment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

**The Express Scripts Pharmacy**

If the primary plan is mail order, complete this form and attach either the prescription receipt(s) that shows the copayment or coinsurance amount paid to the mail-order pharmacy or the statement of benefits you receive from the mail-order pharmacy.

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The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

PLEASE NOTE: Brand-name drugs may move to nonformulary status if a generic version becomes available during the year. Not all the drugs listed are covered by all prescription plans; check your benefit materials for the specific drugs covered and the copayments for your prescription plan. For specific questions about your coverage, please call the phone number printed on your member ID card.

You can find more information at express-scripts.com.
Please note that product placement for Hepatitis C and Treatment for Inflammatory Conditions are under consideration and changes may occur based upon changes in market dynamics and new product launches.

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This document is effective January 1, 2018 through December 31, 2018. This list is subject to change.

You can find more information at express-scripts.com.