THE HOPI TRIBE

2023 Employee Benefits Guide

SUMMIT

Taking Service to the Next Level

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ABOUT THIS BENEFITS GUIDE

This guide summarizes the benefits offered to eligible employees and their dependents. For more details & additional information, contact your Human Resources representative or refer to the Plan Document or Summary of Benefits and Coverages, found on the Summit Employee Portal.

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TERMS TO KNOW

Coinsurance - the amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage.

Deductible - the amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

Copayment (Copay) - The amount you pay to a healthcare provider at the time you receive services.

Explanation of Benefits (EOB) - the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Out-of-pocket maximum - the most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance

Frequently Asked Questions

When do my benefits begin?

Eligible employees are covered under the Plan as of their date of hire, provided a properly completed enrollment form was submitted to the employer. If the employee's dependent(s) are not enrolled for coverage within thirty (30) days of meeting the Plan's eligibility requirements, those dependents will not be eligible to enroll in coverage until the next Open Enrollment period or during a Qualifying Event.

Will I receive an insurance card?

No major changes have been made to the insurance Cards, so you may continue to use your insurance card for this next Benefit Year. New employees electing coverage or those making changes to medical, dental and/or vision coverages will receive a new insurance card. In the event you misplace your card(s), please contact the Office of Human Resources, visit the Summit website or mobile app to order a replacement.

Please note: All insurance cards are mailed directly to the Office of Human Resources.

What if I am eligible for Indian Health Services?

Indian Health Service (IHS) is an agency within the Department of Health and Human Services that is responsible for providing federal health services to American Indians and Alaska Natives. When you receive services at IHS, there is no out-of-pocket cost to you. The cost of services is paid for by the Federal Government, not by The Hopi Tribe's Employee Benefit Plan.

What if I am referred by IHS to a non-IHS provider?

When you are referred by IHS to another provider, the services are still covered through IHS. You are required to notify Summit and The Hopi Tribe's Employee Benefit Plan of the IHS referral so the benefits will be paid appropriately by the Federal Government, not by The Hopi Tribe's Employee Benefit Plan.

What if I prefer to self-present to a network (Blue Cross Blue Shield of AZ) provider?

When you choose to make an appointment on your own, you will provide the office with your Hopi Tribe Employee Benefit Plan ID card. Contracted providers will submit the billing on your behalf and this Plan will pay for covered services based on the Plan Document and Schedule of Benefit amounts. If you see a non-contracted provider, you may be required to submit the billing directly to Summit indicating your employer and legible name on the statement .

Coordination of Benefits

If you or your dependents have coverage under this Plan AND another Plan, including AHCCCS or Medicare the two plans will coordinate benefits. This Plan that covers the employee is secondary to AHCCCS and Medicare for the employee. Generally when children are covered under both parent's plans, the parent's birthdate which falls the earliest in the year will be the primary payer. To contact AHCCCS call 1-855-432-7587 - Calls Answered Monday through Friday 8 a.m. – 5 p.m. or to contact Medicare call1-800-MEDICARE (1-800-633-4227).

Eligibility for Benefits

What does annual "Open Enrollment" mean?

Open enrollment provides a window for you to make changes to your plan elections one time per year without having a reason to do so. Outside of the Open Enrollment window you are typically locked into your benefit elections for the year.

Mid-year changes are ONLY allowed if a Qualified Change, or Life Event occurs. You must notify Human Resources and complete an enrollment form within thirty (30) days following the date of any qualifying event.

Examples of Qualifying Life Events are:

- Marriage, legal separation or divorce
- Change in a child's dependent status
- Death of spouse, child or other qualified dependent
- Spouse's open enrollment
- Change in spouse's employment and / or insurance
- Birth or adoption of a child
- Assignment of legal guardianship
- Loss of insurance coverage
- New coverage under another plan
- Active member in the armed forces

Who is considered an eligible dependent?

In general, full time employees working thirty (30) or more hours per week are eligible for the benefits outlined in this overview. You can enroll the following family members in your medical, dental and vision plans.

- Your legal spouse
- Dependent Child(ren) are covered under the same Plan elected by the employee and may include Medical, Dental & Vision benefits until the child reaches age twenty-six (26) regardless of marital status, residency, or student status:
    - The employee's child(ren) that are natural, adopted, fostered or a step child;
    - Child (ren) for whom the employee or spouse has gained legal guardianship (approved by their village or through the tribal court).

How do I add or terminate a dependent spouse and/or child(ren) to/from my benefit plan?

You may add your eligible dependents when you first become eligible for coverage, or during any open enrollment period. If you do not enroll eligible family members initially, certain Qualifying Events will allow you to enroll your dependents onto your plan during the year (see above for examples).

Termination of coverage for your dependents can only be requested during open enrollment or if there is a qualifying event.

You must complete an enrollment form and provide applicable documentation to make the changes no later than thirty (30) days after the qualifying event.

Please refer to your Plan Document located on Summit's website or call a Customer Service Representative at Summit.

Dependent Health Coverage

EMPLOYEE INSURANCE BENEFITS ARE 100% PAID BY THE HOPI TRIBE

Medical Coverage through a PPO (BCBSAZ)
Prescriptions (Rx)
Dental
Vision
Short Term & Long Term Disability
Life, Accidental Death & Dismemberment

CALENDAR YEAR 2023 RATES

To add CHILDREN	MONTHLY RATE	BI-WEEKLY PAYROLL DEDUCTION
MEDICAL (1 child)	$54.00	$27.00
DENTAL (1 child)	$25.20	$12.60
VISION (1 child)	$14.40	$7.20
MEDICAL (2 or more children)	$108.00	$54.00
DENTAL (2 or more children)	$37.80	$18.90
VISION (2 or more children)	$21.60	$10.80

To add SPOUSE	MONTHLY RATE	BI-WEEKLY PAYROLL DEDUCTION
MEDICAL	$126.00	$63.00
DENTAL	$25.20	$12.60
VISION	$14.40	$7.20

To add SPOUSE & CHILD(REN)	MONTHLY RATE	BI-WEEKLY PAYROLL DEDUCTION
MEDICAL (spouse & 1 child)	$180.00	$90.00
DENTAL (spouse & 1 child)	$45.00	$22.50
VISION (spouse & 1 child)	$27.00	$13.50
MEDICAL (spouse & 2 or more children)	$234.00	$117.00
DENTAL (spouse & 2 or more children)	$67.50	$33.75
VISION (spouse & 2 or more children)	$40.50	$20.25

Medical ~ PPO Network

Your PPO Network is BCBS of AZ that consists of medical care professionals who provide a discounted rate for their services. Below are the amounts you as a member are responsible to pay for covered services.

Benefit year is: January 1st through December 31st	**In-Network** BlueCross BlueShield of Arizona	**Out-of-Network**
You can locate a PPO provider online at: www.azblue.com/CHSnetwork		
Deductible (per Benefit Year) Individual Family	 $100 $300	 $850 $2,250
Out of Pocket Maximum (Includes Deductibles/Copays) Individual Family	 $2,000 $6,000	 Unlimited Unlimited
Preventive Care: Adult / Child	Covered 100% by the Plan	Deductible / 50%
Dr. Office Visits (Primary Care or Specialist)	$10 copay; deductible waived	Deductible / 50%
Ambulance	Deductible /80%	Deductible / 50%
Emergency Room	$150 copay (waived if admitted) (then 100% after deductible is met)	
Inpatient Hospital	$200 copay (per admission) (then 100% after deductible is met)	Deductible / 50%
Outpatient Surgery	$200 copay (then 100% after deductible is met)	Deductible / 50%
Urgent Care	$25 copay; deductible waived	Deductible / 50%
Lab or X-rays. MRI, CT Scans	$100 copay (then 100% after deductible is met)	Deductible / 50%
Hearing Benefit	$25 copay; deductible waived ($1,500 maximum benefit every 2 years for hearing aid appliances)	
Mental Health Outpatient Inpatient	 $10 copay; deductible waived $200 copay (per admission)	 Deductible / 50% Deductible / 50%
Chiropractic Care	$15 copay; deductible waived (12 maximum treatments per benefit year)	Deductible / 50%
All other Covered Services	Deductible /80%	Deductible / 50%

Precertification / Preauthorization

Utilization Review / Large Case Management

Certain medical services require precertification/preauthorization. This is the process of determining if services are medically necessary. Failure to comply may result in denial of benefits, an additional deductible, copay or reduction of benefits. The following are some of the services that MUST be precertified or preauthorized:

- **Inpatient Hospitalization including Mental Health/Substance Abuse**
- **Outpatient Surgery**
- **Home Health Care**
- **Hospice Care**
- **Prosthetics**
- **Extended Care Facility.**

Precertification may be obtained by calling Hines & Associates at **(800) 944-9401**.

Precertification Penalty

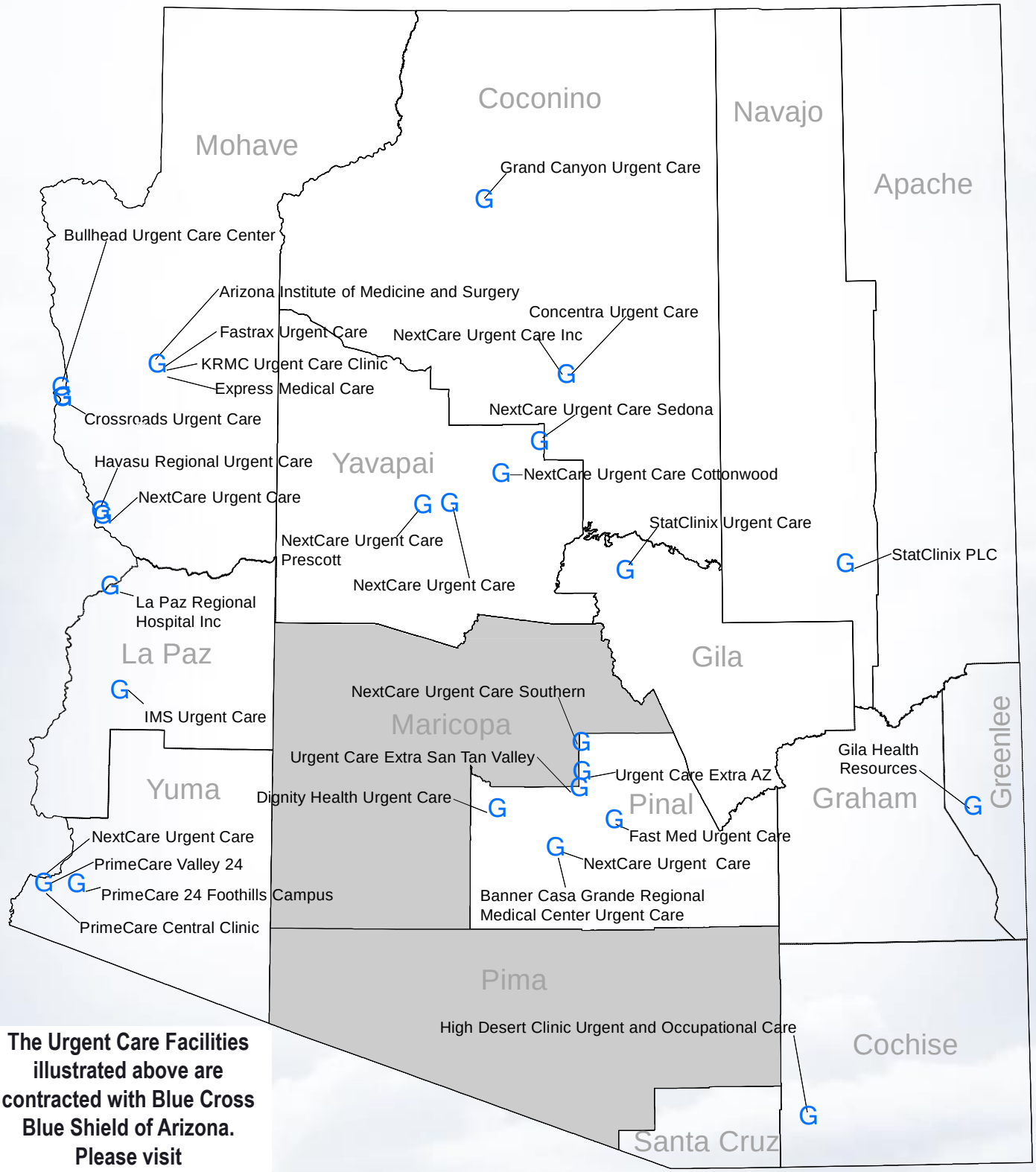
Failure to obtain pre-certification will result in a financial penalty or denied claim. If a covered treatment is not pre-certified, benefits payable for covered expenses for any service requiring precertification shall be reduced by fifty percent (50%) up to a maximum penalty of one thousand dollars ($1,000). For a detailed listing please refer to your plan document on-line at www.summit-inc.net or contact Summit's Customer Service Department at (888) 690-2020.

Prescriptions

100% Plan payment after copay	In-Network Magellan Rx MANAGEMENT SM	Mail Order
• Contraceptives and PPACA mandated & Over the Counter (OTC):	$0	$0
• Generic:	$3	$6
• Formulary Brand Name:	$20	$40
• Non-Formulary Brand Name:	$40	$80
• Specialty Medications:	$60	$120
If the covered person purchases a brand name drug when the physician has indicated a generic drug can be dispensed, the covered person will be required to pay the difference between the cost of the generic drug and the brand name requested, plus the applicable copay.		
www.magellanrx.com	Phone: 1-800-424-3312	Fax:1-888-656-4139

Urgent Care Centers

Rural Arizona
32 Locations



The Urgent Care Facilities illustrated above are contracted with Blue Cross Blue Shield of Arizona. Please visit www.bcbsaz.com/chsnetwork for the most current list of contracted centers.

Health Insurance Card

THE HOPI TRIBE

Employee Benefits Plan
Medical / Pharmacy / Dental / Vision
PPO Medical Group # HPT001
Member ID: Use Member SSN

Dental: Go to any licensed dental provider; submit claims to Summit EDI #86083
Vision: Go to any licensed vision provider; submit claims to Summit EDI #86083

Questions regarding Eligibility & Claims:

SUMMIT

PO Box 25160
Scottsdale, AZ 85255-0102
(888) 690-2020
www.summit-inc.net

Per Benefit Year	In Network	Out of Network
Deductible:	$100 Individual $300 Family	$850 Individual $2,250 Family
Out of Pocket Maximum:	$2,000 Individual $6,000 Family	No Limit No Limit
PCP/Specialist Visit:	$10 Copay	Deductible + 50% Coinsurance
Urgent Care Visit:	$25 Copay	Deductible + 50% Coinsurance
Emergency Room:	$150 Copay (waived if admitted to hospital)	

RXBIN: 017449
RXPCN: 6792000
RXGRP#: PRXSAS

MagellanRx MANAGEMENT

Pharmacy Customer Service:
(800) 424-0472
www.magellanrx.com

FAILURE TO OBTAIN PRECERTIFICATION WILL REDUCE BENEFITS

Precertification required prior to all inpatient hospital, outpatient surgical procedures, extended care facility, behavioral health residential stays, home health care, hospice care, prosthetics, Botox procedures, and the following procedures if medically necessary: diagnostic colonoscopies, vein procedures and dental procedures.

For ALL emergency treatment, call within 24 hours.
Failure to call Hines & Associates shall result in Plan's denial of benefit payment.

Hines

HINES & ASSOCIATES:
(800) 944-9401
www.precertcare.com

To find a Medical Provider or Facility visit:
http://www.azblue.com/chsnetworkmayo

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association

BCBSAZ contracted Providers/Facilities within the state of Arizona should transmit electronic claims directly to BCBSAZ using EDI #53589 or PO Box 2924, Phoenix, AZ 85062-2924

Arizona network provided by Blue Cross ® Blue Shield ® of Arizona (BCBSAZ), an independent licensee of the Blue Cross Blue Shield Association. BCBSAZ provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross Blue Shield plans outside of Arizona

Dental Benefits

Benefit year is January 1st through December 31st	Plan Allowance
Plan Year Deductible	**$50**
Family Deductible (Aggregate)	**$150**
Plan Year Max Per Covered Person - Basic and Major services per benefit year. - Preventative Services of routine oral examinations and prophylaxis shall not apply to the maximum benefit accumulation.	**$2,500**
Percentage of Customary & Reasonable Amount Payable	
Preventive (Routine Exam (3 per benefit year), Cleanings, X-rays)	**100%**
Basic (Restorative, Periodontics, Endodontics, Oral Surgery)	**100%**
Major (Crowns, Bridges, Dentures, Implants)	**100%**
Local anesthesia is covered by the dental plan as noted above. Intravenous anesthesia that is not administered by the dentist is not covered by the plan. Please request a cost estimate prior to receiving basic and major services.	
Orthodontia (For dependents 18 years and under)	
Coinsurance	**50%**
Maximum Benefit per covered person while covered under this Plan	**$3,000**
There is no dental network for the dental plan. You may visit any provider of your choice. Charges may vary by provider.	

Vision Benefits

Benefit year is January 1st through December 31st	Plan Allowance
Exam Includes Intraocular Pressure including dilation (Puffer) Test (anesthetic eye drops)	**Covered up to $150 benefit allowance per benefit year**
Conventional Lenses, Frames and/or Contact Lenses Lenses: Single Vision, Lined Bifocal, Lined Trifocal, Progressive Lenses Enhancement: Anti-reflective Coating, Polycarbonate Lenses, Tints/Photo chromatic adaptive lenses, Scratch-resistant Coating	**Covered up to a $800 maximum benefit combined allowance for lenses, frames and/or contacts per covered person per benefit year**
Repair/Replacement For dependents 18 years and under MUST bring in broken pair into the provider from which the glasses were originally purchased	**Covered up to a $600 maximum benefit combined allowance for lenses and frames per covered person per benefit year**
Retinal Screening High resolution imaging systems to take pictures on the inside of the eye	**$0 copay Once per benefit year**
Diabetic Routine Eye Exam Testing Services related to Diabetic Eye Disease, Glaucoma and Age-related Macular Degeneration (AMD) Retinal screening for covered persons with diabetes	**$0 copay per visit as needed**
Lasik or other Refractive eye surgeries Maximum Benefit per covered person while covered under this Plan	**$1,000 per eye per lifetime**
Cataracts and Glaucoma of medical necessity are covered under the medical plan. Medical deductibles and copays apply per procedure. Precertification is required.	
There is no vision network for the vision plan. You may visit any provider of your choice. Charges may vary by provider.	

Short Term Disability

The Hopi Tribe provides eligible employees Short Term Disability (STD) and Long Term Disability (LTD) Insurance at no cost to employees. This coverage is intended to provide employees with peace of mind in the event they exhaust their paid time off benefits and are not able to work due to illness or injury.

The Short Term Disability benefit replaces a portion of your pre-disability earnings, less the income that was actually paid to you during the same disability from other sources (e.g., state disability benefits, no fault auto laws, sick pay, vacation pay, etc.).

Waiting Period:	**Benefits begin after fourteen (14) calendar days of disability.**
Maximum Weekly Benefit:	60% of base weekly earning not to exceed $750 per week
Maximum Payment Period:	24 Weeks
Employees who are covered under this Plan on the renewal effective date are covered immediately. Newly hired employees are covered after thirty (30) days of employment.	

Long Term Disability

Waiting Period:	**180 days from the date of the disability (term of the STD).**
Maximum Monthly Benefit:	60% of the employee's salary, not to exceed $5,000 per month.
Maximum Payment Period:	2 Years
Benefits are offset by income from other sources including Social Security or Worker's Compensation.	

THE HARTFORD

Life Insurance / AD&D

The Hopi Tribe provides eligible employees Basic Life and Accidental Death & Dismemberment coverage at no cost to the employees. This coverage is intended to provide employees with peace of mind and families and/or beneficiaries with financial security in the event of the employee's death.

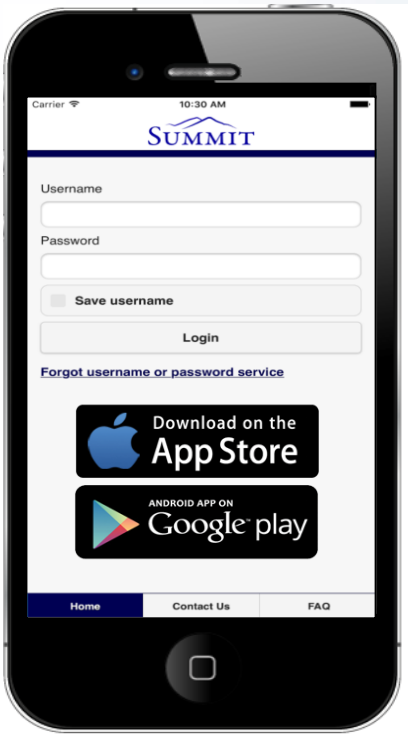
- If an employee has a terminal illness with a life expectancy of no longer than 24 months, the policy will pay while still alive – up to a maximum of $10,000.
- AD&D also pays a portion of the benefit in the event of certain accidental injuries resulting in dismemberment, but not death.

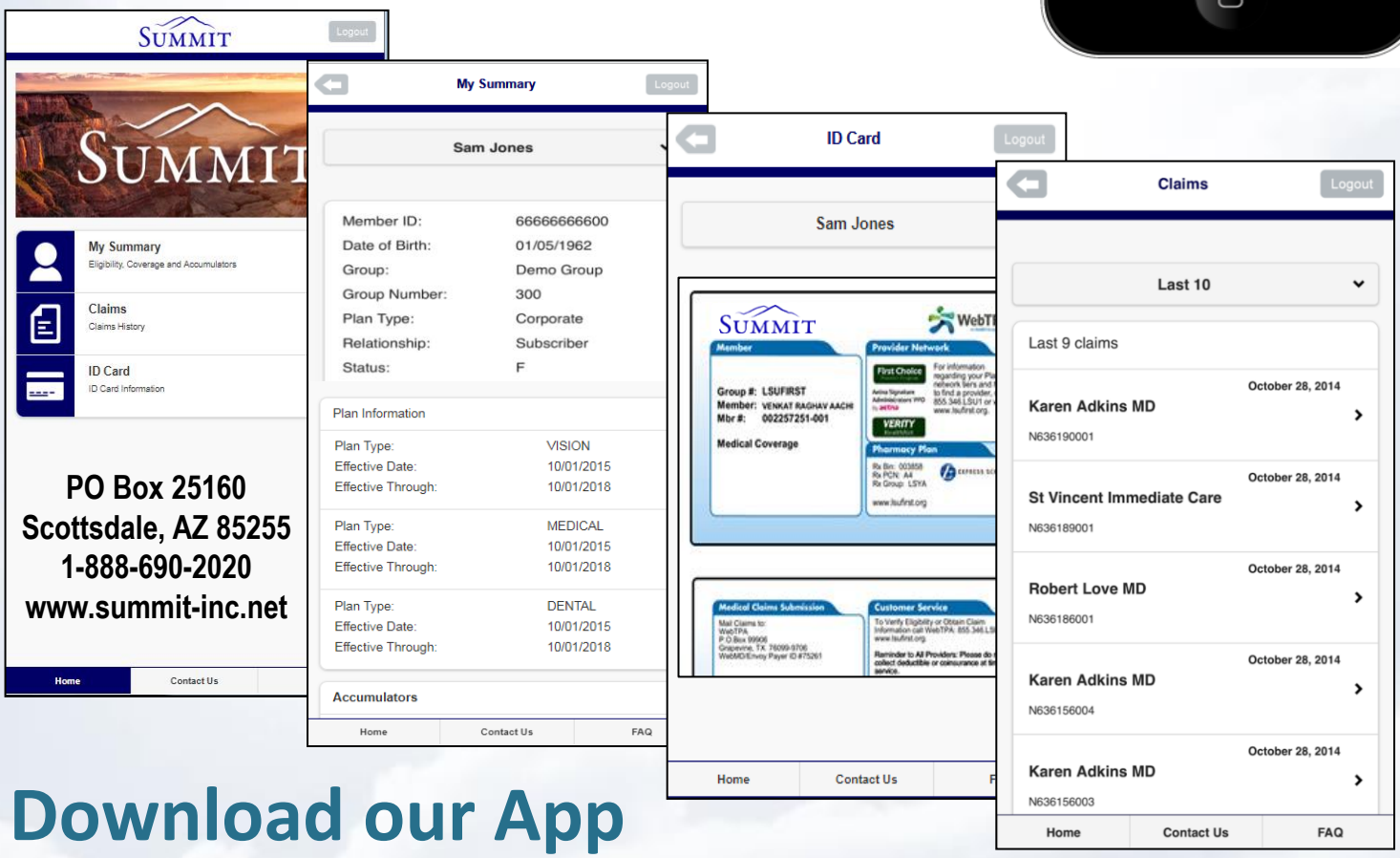
Employer Paid - $50,000 Life Insurance Benefit			
Percentage by which original amount of coverage will be reduced	Age 65	35%	**= $32,500 Death Benefit Payout**
	Age 70	60%	**= $20,000 Death Benefit Payout**
	Age 75	**75%**	**= $12,500 Death Benefit Payout**

Benefit Information at your Fingertips!

Summit offers mobile solutions that give you the tools and resources to have on demand access to your health care benefits

- ✓ Eligibility
- ✓ Coverages
- ✓ Accumulators
- ✓ Claims
- ✓ ID Card Image
- ✓ Contact Us
- ✓ Messaging
- ✓ FAQs





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Federal Notices

The Plan is a non-Federal governmental plan, sponsored by a Federally recognized Indian tribal government. The Hopi Tribe and the Plan are exempt from many Federal requirements that apply to private sector plans. In certain cases, the Plan includes benefits and procedures that are not legally required to be offered, but the Tribe voluntarily models benefits and procedures after the Federal requirements for private sector plans (such as COBRA). Nothing in the Plan documentation or Plan administration shall be construed as a waiver of any exemptions that are available to the Plan or the Tribe under Federal law.

The Department of Labor (DOL), the Department of Health and Human Services (HHS) and the Internal Revenue Service (IRS) require certain information related to health benefit plans be issued to employees in writing. These notices explain your rights and obligations in relation to the health plan provided by your employer. Please note this is not a legal document and should not be construed as legal advice.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits for limited periods of time under certain circumstances, such as, voluntary or involuntary job loss, reduction in the hours worked, death, divorce, and other events. Qualified individuals may be required to pay the entire cost for coverage up to 102% of the cost for the Plan.

FAMILY MEDICAL LEAVE ACT (FMLA) The Family Medical Leave Act entitles eligible employees of covered employers to take unpaid, job-protected leave due to a serious health condition for the employee or immediate family. To be eligible, the employee must have worked at least 1,250 hours during the prior 12 consecutive months. For additional details, visit the Department of Labor FMLA page. Notify your employer when you have a qualifying event, such as, birth or adoption of a child, a serious health condition, need to care for a spouse, child or parent with a serious medical condition, or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)-PRIVACY NOTICE One of the many components of the Health Insurance Portability and Accountability Act (HIPAA) is privacy of an individual's Protected Health Information (PHI). The HIPAA privacy rule requires a health plan to remind employees no less frequently than once every three years of the availability of its notice of privacy practices as well as how to obtain a copy. Remember, it is the privacy practices adopted by your employer that must be distributed to all employees. You can access additional information about the required reminder notice to employees at the Office for Civil Rights website, http://www. hhs.gov/ocr/hipaa and clicking on FAQs, Notice of Privacy Practices.

HIPAA SPECIAL ENROLLMENT RIGHTS if you and/or your dependents lose other group health coverage, or you acquire a dependent, such as, marriage, birth or adoption, you have special enrollment rights in the employer's group health plan allowing you to enroll dependents during the year other than open enrollment. You must submit a completed application for enrollment in the health plan to the employer within 30 days of the loss of other coverage or dependent acquisition in order to enroll the dependents. Failure to enroll within 30 days results in waiting until the next open enrollment.

MEDICAID AND CHILD HEALTH INSURANCE (CHIP) If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have a premium assistance program that can help pay for coverage. If you or your dependent(s) are not currently enrolled in Medicaid or CHIP, and you think your dependent(s) might be eligible, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer sponsored plan. Once it is determined that you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit your dependent(s) to enroll in the Plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. You have 60 days to request coverage after it is determined you are eligible for premium assistance. Arizona CHIP telephone: (Outside of Maricopa County): 1-877-764-5437 (Maricopa County): 602-417-5437

Arizona CHIP website: www.azahcccs.gov/applicants/default.aspx

Federal Notices

MEDICARE PART D NOTICE Your employer will issue a notice about Medicare Part D in September or October. The notice explains the options you have under Medicare prescription drug coverage. It also has information about your current prescription drug coverage with your employer. It will guide you where to find more information to help you make decisions about your prescription drug plan. If you or any of your eligible dependents are eligible for Medicare, please read the notice. If you are not, you can disregard the notice.

THE GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA) is designed to prohibit the use of genetic information in health insurance and employment. The Act prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individual's genetic information when making hiring, firing, job placement or promotion decisions.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) A qualified medical child support order is issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits. An "alternate recipient" is any child of an employee or spouse (including a child adopted by or placed for adoption) who is recognized under a medical child support order as having a right to enrollment under a group health plan. Upon receipt, the employer is required to determine within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each qualified order. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer. Like most other prescribed timelines for enrolling under this provision, you must provide a completed application for enrollment for the alternate recipient within 30 days of the court order.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT NOTICE (USERRA)
Your right to continued participation in the Plan during leave of absences for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act. Accordingly, if you are absent from work due to a period of active duty in the military for less than 30 days, your Plan participation will not be interrupted. If the absence is more than 30 days, but not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 30 days or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA only under the medical coverage for the 24-month period that begins on the first day of your leave of absence. You must pay the cost for COBRA with after-tax funds, subject to the rules that are set out in the Plan.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) The Women's Health and Cancer Rights Act (WHCRA) provides protection for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Contacts

Life Insurance, AD&D, STD, LTD THE HOPI TRIBE	**(928) 734-3212** **HumanResources@hopi.nsn.us** **P.O. Box 123** **Kykotsmovi, AZ 86039**
CLAIMS: **MEDICAL, DENTAL & VISION** SUMMIT **THIRD PARTY ADMINISTRATOR**	**(888) 690-2020** **www.summit-inc.net** **P.O. Box 25160** **Scottsdale, AZ 85255-0102**
PROVIDER SEARCH BlueCross BlueShield of Arizona	**(855) 725-8329** **www.AZBlue.com/chsnetworkmayo**
PRECERTIFICATION / UTILIZATION REVIEW Hines	**(800) 944-9401** **www.precertcare.com** **15 E. Highland Ave** **Elgin, IL 60120**
PRESCRIPTION BENEFITS MANAGER MagellanRx MANAGEMENT	**(800) 711-4550** **www.magellanrx.com** **P.O. Box 13776** **Scottsdale, AZ 85267**
401K INVESTMENT ADVISORS RETIREMENT WEALTH PARTNERS LLC	**(520) 775-2900** **(800) 297-8918** **www.wealthadvisorsllc.com** **Timothy M. Schannep, CFP** **Jason S. Kennedy, AIF**
RECORDKEEPER (NON-INVESTMENTS)/ 401K TRANSAMERICA	**(800) 401-8726** **www.transamerica.com**
Indian Health Service The Federal Health Program for American Indians and Alaska Natives **72-Hour Notification for Emergency Room services**	**(888) 827-4202** **https://www.ihs.gov**