Avondale Human Resources

City of Avondale
2020-21 Annual Enrollment Benefits Guide

AZMT ARIZONA Metropolitan Trust

ANNUAL ENROLLMENT

IS APRIL 20 THROUGH MAY 11, 2020!

Tips

- Review important benefit changes for 2020-21 (page 6)
- Please see the updated pre-certification list on the flyer included in your packet (This is the 2nd flyer in your packet.)
- Contact Human Resources at 623.333.2200 if you have any questions on health plan benefits
- Enroll or make changes using at https://workforcenow.adp.com/login
- Select the plans that are right for you. Review the Medical/Rx plan comparison charts (pages 15-17), dental and vision benefits (pages 18-21), and life insurance information (pages 21-23)
- Don't delay – enroll or make your changes on or before May 11, 2020
- Submit any additional required documentation to HR by May 11, 2020
- Detailed benefit plan information and more can be found in this benefits guide or online at: www.azmt.org/city-of-avondale/open-enrollment-resources

This Benefits Guide gives you an overview of your benefits including eligibility, plan options, rates, how to enroll, and other important information. More detailed information is available in the official plan documents. For information about your other City benefits, please go to www.avondaleaz.gov/government/departments/human-resources/benefits

In the case of conflict between the information presented in the Benefits Guide and the official Plan documents, the Plan Document(s) determines the coverage.

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AS YOU ENROLL

The City of Avondale offers a comprehensive health and welfare benefits program designed to meet the needs of our diverse workforce.

The benefits and premium costs contained in this Benefits Guide are effective July 01, 2020 through June 30, 2021.

This Benefits Guide is designed to help you make informed decisions regarding your benefit elections during the 2020-21 Annual Enrollment period. It highlights your options and key program features to consider before making enrollment elections. You will also find medical plan comparison charts for convenient at-a-glance referencing, enrollment instructions, and plan contact information. Please review the materials carefully and choose the plans that best meet your needs.

Items to Consider During the Annual Enrollment Period

Dependent data:

Gather this information before proceeding with enrollment: Names, birthdates, and social security numbers to complete your enrollment process.

Beneficiary designations:

There are not set deadlines for updating your beneficiary designations, but the Annual Enrollment Period is a great time for you to update them to ensure they are current.

Personal information:

If you've moved or changed your contact information, be sure to enter the change in ADP. If you changed your name, notify your HR department. It's important to keep your personal information up-to-date at all times.

We encourage you to use this Benefits Guide as a reference throughout the plan year. If you have questions, contact the HR Department or the plan providers directly. Plan phone numbers and websites are listed in the Contact Information section on page 28 of this Benefits Guide.

Medical Plan Options

The City of Avondale will continue offering three Medical plans, one Dental and one Vision plan through the Arizona Metropolitan Trust (AzMT) utilizing the Blue Cross Blue Shield of AZ (BCBSAZ) network for medical, Delta Dental of Arizona for dental and VSP for vision. The medical plan options are:

- High Deductible Health Plan (HDHP)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)

The three plans all have similar benefits, but there are different out-of-pocket maximums, deductibles, coinsurance and copays. Please review the Medical Comparison Chart carefully. Employees who are considering enrolling in one of the medical plans should also review the Summary of Benefits and Coverage (SBC) for more specific plan information, available online at www.azmt.org/city-of-avondale/open-enrollment-resources.

BENEFIT CHANGES 2020-21

ARIZONA METROPOLITAN TRUST (AzMT)

The following changes will be effective for **AzMT benefit plans** effective July 01, 2020:

Medical/Rx

EPO

- Increase Deductible from $250/$500 to $300/$600
- Increase Out-of-Pocket Max from $2,500/$5,000 to $2,750/$5,500
- Increase Office Visit Copays from $15/$30 to $20/$40
- Increase ER Copay from $150 to $300 (Waived if Admitted)
- Increase Rx 30 Day Retail Copays from $10/$30/$50 to $15/$35/$55
- Increase Rx 90 Day Retail Copays from $25/$75/$125 to $30/$80/$130
- Increase Specialty Copay from 20% to $200 Max to 20% to $300 Max

PPO

- Increase In-Network Deductible from $500/$1,000 to $750/$1,500
- Increase Out-of-Network Deductible from $1,000/$2,000 to $2,000/$4,000
- Increase In-Network Out-of-Pocket Max from $3,000/$6,000 to $3,500/$7,000
- Increase Office Visit Copays from $20/$40 to $25/$45
- Increase ER Copay from $250 to $300 (Waived if Admitted)
- Increase Rx 30 Day Retail Copays from $10/$30/$50 to $15/$35/$55
- Increase Rx 90 Day Retail Copays from $25/$75/$125 to $30/$80/$130
- Increase Specialty Copay from 20% to $200 Max to 20% to $300 Max

HDHP

- Increase Deductible and Out-of-Pocket Max from $2,700/$5,400 to $2,900/$5,800

Administrative

- Medical Management to AmeriBen
  - Please see the updated pre-certification list on the flyer included in your packet.

If you have any questions about these changes and how they impact your coverage, please contact your Human Resources Department.

AzMT ARIZONA Metropolitan Trust

ANNUAL ENROLLMENT PERIOD – APRIL 20 THROUGH MAY 11, 2020

The Annual Enrollment Period is your once-a-year opportunity to make changes to your current benefit elections for the coming plan year, July 01, 2020 through June 30, 2021, without having a qualifying event.

WHAT CAN I DO DURING THE ANNUAL ENROLMENT PERIOD?

- ✓ Enroll or waive coverage (due to enrollment in other group coverage).
- ✓ Change your medical plan or dental/vision plan.
- ✓ Add or waive (due to enrollment in other group coverage) medical and/or dental and vision coverage for your dependents.
- ✓ Apply for supplemental and/or dependent life insurance. Note: Supplemental life insurance takes effect after approval from Minnesota Life.
- ✓ You need to take action during Annual Enrollment Period and complete your online enrollment. **If no action is taken, you may not have benefits for the 2020-21 plan year.**

SUBMITTING ANNUAL ENROLLMENT PERIOD ELECTIONS AND DEADLINE

Benefit elections and/or changes to your existing benefits are made online through the City's ADP system.

To begin the ADP benefit enrollment/change process, you will need an ADP sign on. If you have forgotten your sign on, please email: bmann@avondaleaz.gov or helpdesk@avondaleaz.gov.

SOCIAL SECURITY NUMBERS FOR YOUR DEPENDENTS ARE REQUIRED!

You are required to provide a Social Security Number (SSN) or a Federal Tax Identification Number (TIN) for your dependent(s) when you enroll them in a City-sponsored medical plan. The City needs this information to comply with IRS reporting. If a dependent does not yet have a social security number, you can go to www.socialsecurity.gov/online/ss-5.pdf to complete a form to request a SSN.

This Annual Enrollment Period is your opportunity to add, drop, or waive coverage for your dependents and to ensure that our records accurately reflect your benefit elections. **If an eligible dependent is not listed in ADP in each of your benefit plans (i.e. medical, dental, and vision), your dependents will not be covered and will not be able to access benefits when seeking services.** Dependents who are no longer eligible should be removed from coverage and failure to do so in a timely manner may result in your liability to repay the Plan if any benefits are paid to or on behalf of an ineligible person.

WHAT IF I WANT TO MAKE A CHANGE MID-YEAR?

In accordance with a federal law, which grants the ability for employers to offer non-taxable benefits to employees, plan elections are irrevocable for the plan year unless a Qualifying Life Event (QLE) is experienced. Requirements of a mid-year change are:

1. Requested change must be consistent with the qualifying mid-year event;
2. Requested change must meet the guidelines of AzMT contracts/agreements, plan documents, and IRC Section 125; and
3. Must be received by HR within **31 days** of the qualifying mid-year event.

To view a summary of the most common qualifying mid-year QLE events, please refer to the Section 125 Change-of-Status Events and Mid-Year Enrollment Changes matrix on pages 9-10 of this Benefits Guide.

EFFECTIVE DATE OF MID-YEAR CHANGES

Elections shall be effective prospectively. Generally, elections that add or change coverage will be effective on the first day of the month following or coinciding with the date the completed online change and applicable supporting documentation is received by HR. (The exception is that when enrollment is requested for a marriage or newborn, newly adopted child or child placed for adoption, coverage is effective on the date of the event, as long as timely election is made). For New Hires, elections are effective on the first day of the month following 31 days of employment in a benefits-eligible position.

Elections that cancel or drop coverage will be effective on the last day of the month in which the qualifying event occurs.

If your coverage was terminated or lapsed while on leave, you will need to re-enroll for coverage through Human Resources upon return from your leave and your coverage will be effective on the first day of the month following your return from leave. If you are returning from a Military leave of absence, your benefits will be effective on the date you return from leave. It is the employee's responsibility to ensure all benefits are active.

FOR NEWBORN CHILDREN

Newborn children must be enrolled in the plan to receive benefits. Failure to request enrollment for your newborn within 31 days of the date of birth will result in your newborn not having coverage from date and time of birth until the next plan year. You will be liable for any services and/or expenses incurred for a newborn who is not timely and properly enrolled.

To enroll your newborn, submit a completed Election/Change Form to HR within 31 days of the newborn's date of birth. If enrollment is requested timely, coverage will be retroactively effective to the date of birth. You are encouraged to request newborn enrollment and submit enrollment paperwork as soon as possible (and no later than 31 days after the date of birth) to avoid non-coverage for your newborn child.

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with AzMT and Section 125 of the IRS.
This chart is only a summary of some of the permitted health plan changes and is not all inclusive

Qualifying Event	Effective Date	You may make the following change(s)[1] Forms must be Received Within:	You May Make the Following Changes(s)
Qualifying Events Chart			
Marriage or registration of domestic partnership	Date of event	Thirty-one (31) days of marriage	Enroll yourself, if applicable Enroll your new spouse and other eligible *dependents*
Divorce, legal separation, or annulment	First of the month following the date of the event	Thirty-one (31) days of the date of final divorce decree or annulment	Coverage will terminate for your spouse Enroll yourself and *dependent* child(ren) if you, or they, were previously enrolled in your spouse's plan
Birth of your child	Date of event	Thirty-one (31) days of birth	Enroll yourself Enroll the newborn child
Adoption, placement for adoption, *foster child*, or legal guardianship of a child	Date of event	Thirty-one (31) days of event	Enroll yourself Enroll the newly adopted child
Your *dependent* child reaches maximum age for coverage	First of the month following the date of the event	*Notify* within thirty-one (31) days of loss of eligibility	Coverage will terminate for the child who lost eligibility from your health coverage
Death of your spouse or *dependent* child	Date of event	Sixty (60) days of spouse's or *dependent's* death	Coverage will terminate for the *dependent* from your health coverage
A *change in employment status* in *employment* classification or work schedule for you, your spouse, or *dependent* child	First of the month following the date of the event	Thirty-one (31) days of *change in employment status* classification	Enroll yourself, if your employment change results in you being eligible for a new set of benefits Enroll your spouse and other eligible *dependents* Drop health coverage Drop your spouse and other eligible *dependents* from your health coverage
Change of residence or worksite if change impairs ability to access *network providers*	First of the month following the date of the event	Thirty-one (31) days of *change in employment status* classification	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Significant change in or cost of your or your spouse's or *dependent's* health coverage due to spouse's or *dependent's* employment, including open enrollment	First of the month following the date of the event	Thirty-one (31) days of effective date of change in coverage	Enroll yourself and other eligible *dependents*
Significant change in benefits	First of the month following the date of the event	Thirty-one (31) days of effective date of change in coverage	Enroll yourself and other eligible *dependents*

[1] Rules apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with AzMT and Section 125 of the IRS.

This chart is only a summary of some of the permitted health plan changes and is not all inclusive

Qualifying Event	Effective Date	You may make the following change(s)[2] Forms must be Received Within:	You May Make the Following Changes(s)
Qualifying Events Chart			
Spouse or covered *dependent* obtains coverage in another group health plan	First of the month following the date of the event	*Notify* within thirty-one (31) day of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	First of the month following the date of the event	Thirty-one (31) days of the date of loss of coverage	Enroll yourself, your spouse and eligible *dependent* children
Spouse's loss of coverage, including COBRA coverage	First of the month following the date of the event	Thirty-one (31) days of the date of loss of coverage	Enroll your spouse and eligible *dependent* children Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan
Eligibility for government-sponsored plan, such as *Medicare* (excluding the government-sponsored Marketplace)	First of the month following the date of the event	Thirty-one (31) days of eligibility date	Drop coverage for the person who became entitled to *Medicare*, Medicaid, or other eligible coverage
CHIP Special Enrollment – Loss of eligibility for coverage under a state Medicaid or *CHIP* program, or eligibility for state premium assistance under Medicaid or *CHIP*	First of the month following the date of the event	Sixty (60) days of loss of eligibility or eligibility date	Enroll yourself, if applicable Add the person who lost entitlement to *CHIP* Drop coverage for the person entitled to *CHIP* coverage
Qualified Medical Support Order affecting a *dependent* child's coverage	First of the month following receipt of the notice	Thirty-one (31) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

[2] Rules apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.

BENEFIT ELIGIBILITY

To be eligible for medical, dental and vision benefits listed in this Benefits Guide, you must be an employee scheduled to work a minimum of 30 hours per week on a regular basis. All new employees will be covered on the first day of the month following 31 days of employment. Coverage will be effective provided proper enrollment has been made and any required contributions have been authorized.

DEPENDENT ELIGIBILITY

If you are eligible to participate in the City-sponsored medical, dental and vision plans, your eligible dependents may also participate. Your eligible dependents include:

- Your lawfully married spouse
- Your domestic partner who is the same or opposite sex as the eligible employee and who has shared a long-term committed relationship with the eligible employee for a minimum of the last twelve (12) months
- You or your spouse/DP's dependents including natural child(ren), legally adopted child(ren), child(ren) placed with you for adoption, eligible foster child(ren), or child(ren) under legal guardianship substantiated by a court order
- Child(ren) under QMCSO
- Dependent child(ren) over the limiting age who are considered disabled

Eligible dependent child(ren) will be covered through the last day of the month of their 26th birthday. It is the employee's responsibility to notify Human Resources of dependent's age. Coverage will be terminated once the dependent reaches age 26, unless Human Resources is notified that the dependent has a qualifying disability.

MEDICAL BENEFITS

As an employee, the health benefits available to you represent a significant component of your compensation package and they provide important protection to keep you and your family in good health. Eligible employees that elect one of the three medical plans will automatically be enrolled in the prescription, wellness program, EAP, and telemedicine benefits which are all included in your premiums. The City of Avondale is pleased to offer you the following medical plans:

- High Deductible Health Plan (HDHP) – $2,900/$5,800
- Preferred Provider Organization (PPO) - $750/$1,500 Deductible
- Exclusive Provider Organization (EPO) - $300/$600 Deductible

When you enroll in a medical plan, you also decide if you want to enroll your eligible dependents in coverage. You can choose two level of coverage: Employee Only or Employee + Family.

If you want dependents to be covered, your eligible dependents have to be enrolled in the same medical, dental and visions plans you select.

AzMT Health Plans

All medical plan options are self-funded, meaning the contributions from the City of Avondale and eligible employees are used to pay plan benefits, including services provided to the members and claims administration.

Blue Cross Blue Shield of Arizona (BCBSAZ) is the network provider and plan members have access to more than 25,100 doctors and specialists that make up a strong local Arizona network. BCBSAZ has contracted with more than 95% of hospitals in Arizona, including 80 acute care hospitals. If you use services in Arizona and within the BCBSAZ network, eligible benefits will be paid based on the benefit level of the plan you chose. If you utilize services outside of Arizona and/or outside of the BCBSAZ network, services will be paid at a Medicare Like Rate and the provider can balance bill you, potentially leaving you with thousands of dollars owed out-of-pocket.

To find a network provider, visit www.azblue.com/chsnetwork or call BCBSAZ at 877.475.8454.

AmeriBen is the Third-Party Claims Administrator and they process medical claims, verify eligibility, answer coverage questions and can assist with ID cards. Visit AmeriBen at www.myameriben.com or call them at 855.350.8699.

Prescription Coverage under Navitus

When you elect medical coverage, you are automatically enrolled to receive prescription drug benefits.

CVS – Please note that CVS is NOT covered under any of the AzMT plans.

Retail Program

You have access to a large national network of retail pharmacies where you can have your prescriptions filled for a 30-day supply of medication. The amount you will be required to pay for the cost of your medication will depend upon the level/tier the prescription falls under. You can locate participating pharmacies and check the prescription level/tier anytime at www.navitus.com.

90 Day Retail Program

Many members require maintenance medications for conditions such as diabetes, high blood pressure, asthma, etc. For these members, Navitus contracts with a robust network of pharmacies that offer up to a 90-day supply of maintenance medications at a discounted copayment.

Mail Order Program

Navitus also offers members a mail order program for filling maintenance medications through Costco. Members are able to receive a 90-day supply of medications mailed to their home for a reduced copayment. You can create an online account at www.pharmacy.costco.com or, if you have additional questions, call 800.607.6861.

Vaccination Program

Navitus has partnered with pharmacies to provide immunizations for members. At participating pharmacies, your copay for vaccines will be $0; available vaccines include: Influenza, Pneumonia, Tetanus/Diphtheria,

Hepatitis A, Hepatitis B, Meningitis, Shingles, MMR, HPV, Pertussis and Varicella. To see if your pharmacy is participating, contact Navitus Customer Care at 866.333.2757.

Dispense as Written Penalty

Members who choose a brand name medication when a generic is available will be subject to a penalty equivalent to the cost difference between the generic and brand.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN

The EPO Plan is a network of hospitals, physicians, medical laboratories, and other health care providers who are located within Arizona and who have agreed to provide medically necessary services and supplies for favorable negotiated discount fees, applicable only to BCBSAZ members.

- **Under the EPO plan there is coverage ONLY when you use an EPO provider.**
    - All care in the EPO plan must be obtained within the plan network, unless you have an emergency.

Most doctor office visits are available at a $20 copay and most in-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost. Other in-network services are covered at 90% after the deductible ($300 per individual or $600 per family) is met.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

A PPO Plan offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates. Under a PPO plan, you may choose the level of benefits you receive based on the providers you use when you receive care. Keep in mind that if you choose to use an out-of-network provider you will be subject to a higher deductible and the provider has the option to balance bill. Most in-network doctor office visits are available at a $25 copay and most in-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost. Other in-network services are covered at 80% after the deductible ($750 per individual or $1,500 per family) is met.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

An HDHP is similar to the PPO plan, in that you can choose between an in-network group of providers and out-of-network providers. Under the HDHP, you are responsible for payment of all services and prescriptions until you meet your deductible/maximum out-of-pocket ($2,900 per individual or $5,800 per family), then eligible services are payable at 100%. In-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost.

KEY ITEMS TO CONSIDER IN CHOOSING A MEDICAL PLAN

- Compare benefit coverage levels and premium costs carefully to see which option best fits your needs.
- In the PPO and HDHP plans, you may obtain services from either In-Network or Out-of-Network providers, but you will pay less out of your own pocket when you use an In-Network provider.
- In the EPO, all services must be obtained from within the EPO network; there are no Out-of-Network benefits except in an emergency.
- Dependents must be enrolled in the same plan as yourself.
- Medical plan costs vary based on the plan and coverage you select. (You and the City share the cost of the premiums.) You pay your share of the cost through payroll deductions for the premiums and when you use services, such as when you pay the cost for deductibles, copays, and the coinsurance.

MEDICAL PLAN COMPARISON

2020-21 Plans and Benefits	HDHP		PPO		EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
Plan Year Deductible					
Single	$2,900	$5,000	$750	$2,000	$300
Family	$5,800	$10,000	$1,500	$4,000	$600
Plan Year Out-of-Pocket Maximum[1]					
Single	$2,900	$10,000	$3,500	$5,000	$2,750
Family	$5,800	$20,000	$7,000	$10,000	$5,500
Allergy Serums and Injections If received during an office visit when a Physician is seen, then paid under the office visit benefit.	0%*	50%*	$0 Copay	50%*	$0 Copay
Allergy Testing and Treatment	0%*	50%*	20%*	50%*	10%*
Hearing Aid Benefit	$1,000**	$1,000**	$1,000**	$1,000**	$1,000**
Genetic Testing (Limitations Apply)	0%*	0%*	20%*	50%*	10*
Ambulance Services	0%*	50%*	20%*	50%*	10%*
Chemotherapy (Outpatient)	0%*	50%*	20%*	50%*	10%*
Chiropractic Care/Spinal Manipulation	0%*	50%*	$25 Copay	50%*	$20 Copay
Plan Year Maximum Benefit	30 Visits		30 Visits		30 Visits
Diagnostic Testing, X-Ray and Lab Services					
Free Standing Laboratory Facility	0%*	50%*	20%*	50%*	10%*
Free Standing Radiology Facility	0%*	50%*	20%*	50%*	10%*
All Other Locations (except office visit)	0%*	50%*	20%*	50%*	10%*
Durable Medical Equipment (DME)	0%*	50%*	20%*	50%*	10%*
Emergency Room	0%*	50%*	$300 Copay + 20%* Copay Waived if Admitted		$300 Copay + 10%* Copay Waived if Admitted
Home Health Care	0%*	50%*	20%*	50%*	10%*
Plan Year Maximum Benefit	60 Visits		60 Visits		60 Visits
Hospice Care	0%*	50%*	20%*	50%*	10%*
Lifetime Maximum Benefit	6 Months		6 Months		6 Months
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)					
Inpatient/Outpatient	0%*	50%*	20%*	50%*	10%*
Maternity					
First Visit to Confirm Pregnancy					
Primary Care Physician	0%*	50%*	$25 Copay	50%*	$20 Copay
Specialist	0%*	50%*	$45 Copay	50%*	$40 Copay
Prenatal and Postnatal Care	0%*	50%*	20%*	50%*	10%*
Delivery Charges	0%*	50%*	20%*	50%*	10%*
Mental Health and Substance Abuse Disorders					
Inpatient	0%*	50%*	20%*	50%*	10%*
Outpatient	0%*	50%*	$25 Copay	50%*	$20 Copay

Outpatient Therapies (e.g., physical, speech, occupational)	0%*	50%*	20%*	50%*	10%*
Plan Year Maximum Benefit	20 Visits		20 Visits		20 Visits
Physician's Services					
Office Visits					
Primary Care Physician	0%*	50%*	$25 Copay	50%*	$20 Copay
Specialist	0%*	50%*	$45 Copay	50%*	$40 Copay
Physician Office Surgery					
Primary Care Physician					
Surgery Costing under $500	0%*	50%*	$25 Copay	50%*	$20 Copay
Surgery Costing over $500	0%*	50%*	20%*	50%*	10%*
Specialist					
Surgery Costing under $500	0%*	50%*	$45 Copay	50%*	$40 Copay
Surgery Costing over $500	0%*	50%*	20%*	50%*	10%*
Preventive Services and Routine Care Preventive Services per Health Care Reform (PPACA) (Includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	0% Deductible Waived	Not Covered	$0 Copay	Not Covered	$0 Copay
Radiation Therapy (Outpatient)	0%*	50%*	20%*	50%*	10%*
Skilled Nursing Facility and Rehabilitation Facility	0%*	50%*	20%*	50%*	10%*
Plan Year Maximum Benefit	60 Days		60 Days		60 Days
Urgent Care Facility ~Copay applies per visit regardless of what services are rendered	0%*	50%*	$50 Copay	50%*	$50 Copay
All Other Eligible Medical Expenses	0%*	50%*	20%*	50%*	10%*

Dual Coverage Not Allowed Reminder… *An eligible employee and his/her eligible dependent(s) may be enrolled in a City-offered medical plan but are allowed only to enroll either as a subscriber in a City-offered medical plan or, as the dependent spouse/DP of another AzMT entity medical plan or, as the dependent spouse/domestic partner of another eligible AzMT employee, but not both. If an employee is also eligible to cover dependent child(ren), each child will be allowed to enroll as a dependent on only one employee's plan (i.e., an employee and his or her dependents cannot be covered by more than one AzMT offered plan).*

[1] **Please note that there is a separate maximum out-of-pocket for prescriptions**

*Applies after deductible

** Lifetime Limit

PRESCRIPTION PLAN COMPARISON

	HDHP	PPO & EPO Plans	
	Network Pharmacy		Out-of-Network Benefit**
Retail Pharmacy: 30-Day Supply			
Generic Drug (Tier 1)	No Charge After Deductible is Met	$15 Copay	Member pays the network pharmacy copay plus the difference between the non-network and network pharmacy amount.
Preferred Drug (Tier 2)		$35 Copay	
Non-Preferred Drug (Tier 3)		$55 Copay	
Specialty		20% to Max of $300	N/A
Retail Pharmacy: 90-Day Supply			
Generic Drug (Tier 1)	No Charge After Deductible is Met	$30 Copay	Member pays the network pharmacy copay plus the difference between the non-network and network pharmacy amount.
Preferred Drug (Tier 2)		$80 Copay	
Non-Preferred Drug (Tier 3)		$130 Copay	
Mail Order Pharmacy: 90-Day Supply			
Generic Drug (Tier 1)	No Charge After Deductible is Met	$30 Copay	N/A
Preferred Drug (Tier 2)		$80 Copay	N/A
Non-Preferred Drug (Tier 3)		$130 Copay	N/A
***CVS is excluded from the pharmacy network.**			
****Members are responsible to pay the difference between the network pharmacy cost and non-network pharmacy cost for all plans.**			
***PPO Rx Max out of pocket is: $3,600 per participant and $7,200 per family. (Same as last year. Ref. Summary Plan Doc)			
***EPO Rx Max out of pocket is: $4,100 per participant and $8,200 per family. (Same as last year. Ref. Summary Plan Doc)			

CITY CONTRIBUTIONS FOR MEDICAL COVERAGE

You and the City share in the costs of your medical plan benefits. The plans are funded through the City's and your contributions toward medical plan premiums; costs are incurred as plan participants seek medical care and claims are paid for that care. As is the case with most health plans, the total medical premium costs increase from year-to-year. In addition, because employees pay the difference between the total premium cost and the City's contribution, premium increases have a direct effect on your contribution cost.

The relationship between premiums and plan participant's use of the plans is important to understand – because plan utilization is a key driver of the premium rates. This means that your decisions as you use your plan benefits can make a difference.

Use your benefits wisely

- Be aware of the costs of the services you select
- Use in-network providers when possible
- Choose generic drugs when possible
- Commit to making healthy lifestyle choices to avoid chronic health conditions

Making the choice to live healthier is one way you can help keep future costs down. Actively participate in the City's wellness program, AzMT L.I.V.E. Let your doctor know that cost is important to you. Talk to your doctor about the cost of care to see if there are more affordable ways to achieve the desired outcome. Do not avoid necessary treatment due to cost. Preventive treatment is shown to save costs in the long run by identifying issues early.

DENTAL BENEFITS

Dental is an important part of your benefits package and regular dental care is key to your overall health. The City is pleased to offer a dental plan administered through Delta Dental of Arizona.

Delta Dental is the country's largest dental network, with more than four out of five of the nation's dentists participating. Participating dentists have agreed to accept pre-negotiated fees for dental procedures and are prohibited from billing a patient above the predetermined amount (balance billing). This arrangement results in protection and savings for patients.

Always request a pre-treatment estimate from your dentist before having major dental work done. Don't be afraid to ask questions! Do not agree to any treatment unless you fully understand what condition is being treated, why it is being treated, and the costs of that treatment. When in doubt, contact Delta Dental.

To learn more about Delta Dental, visit www.deltadentalaz.com or call 800.352.6132.

DENTAL BENEFIT HIGHLIGHTS

Plan Benefits		
Individual Deductible per Plan Year	$50	
Family Deductible per Plan Year	$150	
Percentage Payable	**In-Network**	**Out-of-Network**
Routine/Preventive Care	100%	80%
Basic Services		
Fillings	80%*	60%*
Endodontics	80%*	60%*
Periodontics	80%*	60%*
Oral Surgery	80%*	60%*
Major Services		
Crowns/Inlays	50%*	40%*
Prosthodontic/Prosthetics	50%*	40%*
Implants	50%*	40%*
Orthodontics (Adult & Child)	50%	50%
Dental Benefit Maximums		
Maximum Payable Per Plan Year	$4,000 Per Person	
Lifetime Orthodontic Benefit	$2,000 Per Person	
Child(ren) Age Eligibility	Age 26	

*Applies after deductible

VISION BENEFITS

Get the best in eye care and eyewear with VSP® Vision Care.

VSP invests in the things you value most—the best care at the lowest out-of-pocket costs. Because VSP is the only national not-for-profit vision care company, you can trust that they will always put your wellness first.

You'll like what you see with VSP…

Value and Savings. You'll enjoy more value and the lowest out-of- pocket costs.

High Quality Vision Care. You'll get the best care from a VSP provider, including a Well Vision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, your satisfaction is guaranteed.

Choice of Providers. The decision is yours to make—choose a VSP provider or any out-of-network provider.

Great Eyewear. It's easy to find the perfect frame at a price that fits your budget.

VISION BENEFIT HIGHLIGHTS

Benefit	
Copay Eye Exam	$10
Copay Contact Lens Exam	Up to $60
Copay Prescription Glasses (Frames & Lenses)	$10
Frame Allowance	$225 Allowance $245 for Featured Frame Brands 20% Savings on Amounts Over Allowance $120 Costco Frame Allowance $120 Walmart Frame Allowance
Lenses	Single Vision, Lined Bifocal and Lined Trifocal Polycarbonate
Lens Enhancements	Standard Progressive Lenses - $25
Contact Lenses (In Lieu of Lenses/Frames) per Plan Year	$175 Allowance
Frequency	Every Plan Year
Child(ren) Age Eligibility	Age 26

VSP Extras – Hearing Aids

Save up to 60% on Brand-name Hearing Aids!

TruHearing makes hearing aids affordable by providing exclusive savings to all VSP vision members.

In addition to great pricing, TruHearing provides you with:

- Three provider visits for fitting and adjustment
- 45-day trial
- 3-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

For more information regarding this added benefit, call 877.396.7194 or head over to www.truhearing.com/vsp.

LIFE INSURANCE

BASIC AND SUPPLEMENTAL LIFE INSURANCE

- Basic Life Insurance, Accidental Death & Disability (AD&D), and Supplemental Life Insurance are insured by Minnesota Life.
- All benefit-eligible employees receive Basic Life Insurance and AD&D benefits paid by the City.
- All benefit-eligible employees may also purchase Supplemental Life Insurance coverage.
- To be eligible to purchase Supplemental Life Insurance the employee **must have** Basic Life Insurance coverage.

LEVELS OF COVERAGE

GUARANTEE ISSUE

Guarantee issue is the amount of supplemental life insurance that you are automatically approved for without providing evidence of good health.

Newly hired or newly eligible employees

If you are a new hire or newly eligible employee and submit your election within 31 days of eligibility, you are automatically approved for a Guarantee Issue of $150,000, your spouse up to $30,000 and your child(ren) $10,000.

During annual enrollment

	Basic Life and AD&D Insurance 100% Paid by the City	**Supplemental Life Employee Paid**
Employee	2X annual salary, up to $200,000 maximum	Increments of $10,000 up to a combined total of $500,000
Dependent Life Package	$5,000 spouse and $2,500 children	Spouse – Increments of $5,000 up to $250,000 (not to exceed employee's total Basic and Supplemental coverage) Child – Increments of $2,500 up to $10,000 (one premium insures all children from live birth to age 26)

- If you are currently enrolled in Supplemental Life Insurance and haven't yet reached the maximum Guarantee Issue, you can elect to increase your coverage by $10,000 without evidence of insurability; if you request more than $10,000 or have exceeded the Guarantee Issue, you will have to provide evidence of insurability.
- **If you are not enrolled in Supplemental Life Insurance, you may elect Supplemental Life Insurance coverage for the first time up to $10,000 without evidence of insurability.** Any other level of coverage you elect is subject to approval by Minnesota Life and evidence of insurability is required. No payroll deductions for amounts that require approval will be taken until your application is approved by Minnesota Life.

SUPPLEMENTAL LIFE INSURANCE COST

The cost of supplemental coverage is based on your age on the last day of the fiscal year (June 30) and the amount of insurance you select. Current rate for each $1,000 in supplement life insurance coverage are listed to the right.

Example: 30-year-old employee interested in $20K of supplemental life insurance:
$.080 x 20 = $1.60 per month or $0.74 per pay period

Insurance amounts are rounded to the nearest thousandth.

2020-2021 Employee Supplemental Term Life	
Age	Employee Rate/$1,000
<25	$0.060
25-29	$0.060
30-34	$0.080
35-39	$0.090
40-44	$0.124
45-49	$0.201
50-54	$0.307
55-59	$0.496
60-64	$0.660
65-69	$1.270
70-74	$2.060
75*	$7.532

*Rates beyond age 75 are available upon request

DEPENDENT LIFE INSURANCE

Supplemental life insurance is available to employees who want to add additional life insurance for their dependents. A spouse can be covered in increments of $5,000 up to $250,000 but cannot exceed the employee's life insurance amounts. Child(ren) can be covered in increments of $2,500 up to $10,000.

The child(ren) rate is $0.13 per $1,000 and one premium covers all children enrolled and the benefit payable is for each child.

Example: Employee with three children interested in $10K of supplemental dependent life insurance:
$.013 x 10 = $1.30 per month or $0.60 per pay period

All children receive a $10,000 benefit.

2020-2021 Spouse Supplemental Term Life	
Age	Spouse Rate/$1,000
<25	$0.049
25-29	$0.049
30-34	$0.050
35-39	$0.066
40-44	$0.093
45-49	$0.141
50-54	$0.214
55-59	$0.356
60-64	$0.538
65-69	$0.914
70-74	$1.624
75*	$3.340

*Rates beyond age 75 are available upon request

KEY POINTS TO CONSIDER ABOUT LIFE INSURANCE

- You pay the full cost of supplemental and dependent coverage on a post-tax basis.
- Especially if you are the sole wage-earner in your family, think about whether or not you need more protection than the City-paid basic coverage provides.
- Consider whether you have enough money to cover funeral and/or legal expenses in the event of a death of a spouse, domestic partner, or children. Dependent life insurance may help with these expenses.
- Be sure to designate a beneficiary (or beneficiaries) for your employee life insurance and keep it up-to-date (basic and supplemental).
- Help is available for determining how much life insurance you may need. Check out the life insurance calculator at www.lifebenefits.com/insuranceneeds to determine the right amount for you.

TAX FREE SAVINGS FOR MEDICAL EXPENSES

HEALTH SAVINGS ACCOUNT (HSA)

What is an HSA?

An HSA is an individual savings account that can be used to pay for qualified medical expenses. The HDHP option allows you to open an HSA and take advantage of terrific tax savings. The money in your account accumulates on a tax-deferred basis and can be rolled over from year to year. You can save your money for future medical expenses, and as long as you use the money for a qualified medical expense, your funds are never taxed. This account is only available if you select the High-Deductible Health Plan (HDHP). A participant cannot contribute to an HSA if they are covered on any other non-qualified plan, are covered as a dependent on another person's tax return (excluding spouses).

How Does an HSA Work?

A High-Deductible Health Plan offers a lower monthly premium in exchange for a higher deductible. The money you would normally spend on monthly premiums can now be contributed on a pre-tax basis to your HSA account. You will receive a debit card to use for qualified medical expenses, which will draw from your HSA. Distributions from your HSA are tax-free when used to pay for qualified medical expenses. The 2020 maximum contribution for single coverage is $3,550, and family is $7,100. HSA participants who are 55 or older can contribute an additional $1,000, or $4,550 for single coverage and $8,100 for family coverage. The City of Avondale uses Health Equity for all HSA accounts. Please note, HSA accounts operate on a calendar-year basis. A participant can elect to contribute the maximum amount from July 1, 2020 - December 31, 2020; however, to avoid tax issues, the individual must remain on the HDHP through the full plan year following elections.

What is considered a "Qualified Medical Expense"?

Some of the most common expenses include*:

Deductible	Contact lenses	Eyeglasses	Over-the-counter medications
LASIK surgery	Office visit co-pays	Dental treatment	Hospital Services
Prescription drugs	Chiropractor visits	Vaccinations	Insurance Premiums

*You should refer to www.irs.gov/pub/irs-pdf/p502.pdf for a full list of qualified expenses. If HSA funds are used for non-qualified medical expenses, those purchases are subject to a 10% penalty tax and will be considered income for tax purposes.

What are the eligibility requirements for an HSA?

The eligibility requirements to open and contribute to a health savings account (HSA) are mandated by the Internal Revenue Service (IRS), not by your employer. Individuals who enroll in a Health Savings Account (HSA) but are later determined to be ineligible for that account are subject to financial penalties from the IRS. It is an individual's responsibility to ensure that he/she meets the eligibility requirements to open an HSA and to have contributions made to that HSA, as outlined below:

- To be eligible to open an HSA and have contributions made to the HSA during the year, an individual must be covered by an HSA-qualified health plan (HDHP) and must not be covered by other health insurance that is not an HSA-qualified plan.

- Certain types of insurance are not considered "health insurance" and will not jeopardize an individual's eligibility for an HSA, including automobile, dental, vision, disability, and long-term care insurance.

IMPORTANT: Individuals enrolled in Medicare are not eligible to open an HSA or have contributions made to the HSA during the year. If you think you could become eligible for Medicare in the next 12 months, you should consider whether enrolling in the medical plan that is paired with a health savings account is a wise choice.

- You may not be claimed as a dependent on someone else's tax return.
- Individuals may not open a HSA, or have contributions made to the HSA during the year, if a spouse's health insurance, Health Care Flexible Spending Account (Health Care FSA) or health reimbursement arrangement (HRA) can pay for any of the individual's medical expenses before the HSA-qualified plan deductible is met. This means that a standard general-purpose Health Care FSA may make you ineligible to open an HSA and have contributions made to the HSA during the year.
- If an individual received any health benefits from the Veterans Administration (or one of its facilities)—including prescription drugs— in the three months prior, he or she is not eligible to open an HSA and have contributions made to the HSA during the year.

What are the benefits of an HSA?

- The contributions are 100% tax-deductible.
- The fund grows tax-deferred.
- The money withdrawn for qualified medical expenses is tax-free.
- The money you put in can reduce your taxable income.
- You can roll the savings over from year to year.
- Your HSA is portable and can move with you from job to job.
- After age 65, you can use your HSA account to pay Medicare premiums, deductibles, co-pays, and coinsurance under any part of Medicare.

How do I pay the bill at my doctor's office with an HSA?
Health Equity offers a debit card for convenient access to your money as well as online banking tools.

If you have an HSA, it is important not to overpay for medical expenses. Since you're paying "cash" from your HSA, if you pay the entire bill up front, you may be paying too much, since network discounts would not have been applied. For example, most claims must be re-priced before you know what you owe. If you pay cash at the time of service, you could be paying before the network discounts are applied. This may pose a problem if you are reimbursed by your physician's office, because you have technically made an unqualified withdrawal from your HSA. We strongly suggest you wait until you receive your Explanation of Benefits (EOB) before paying the provider.
For questions, contact Health Equity at 866.346.580 or online at www.healthequity.com.

MEDICAL FLEXIBLE SAVINGS ACCOUNT (FSA)

The 2020 maximum contribution amount is $2,600. The FSA is an annual election and you must re-enroll each year to participate. FSA accounts are "use it or lose it" programs. You will gain the most savings if you plan carefully and contribute only what you estimate your eligible expenses will be. At the end of the plan year, unused funds are forfeited. Please note, eligible expenses are clearly defined by the IRS - for more information on eligible expenses, visit www.irs.gov/publications/p502/index.html. Sheakley administers the FSA account and can be reached by calling 800.877.2053 or logging on to https://sheakleycdhee.lh1ondemand.com.

If selecting the Flexible Spending Account (FSA) you must re-select it in the ADP benefit enrollment module regardless if you had the benefit in 19-20. If the FSA is not re-selected, you will not be enrolled for the 20-21 fiscal year.

DEPENDENT DAYCARE FLEXIBLE SPENDING ACCOUNT (DDC)

Employees may also elect to participate in the DDC account which allows you to pay for dependent care expenses with tax-free dollars for eligible dependents. The maximum contribution amounts are $5,000 or $2,500 if married and filing separate. Dependent Daycare eligible expenses are for children under the age of 13 and dependents of any age who are physically or mentally unable to care for themselves. By enrolling in this plan, you save money on daycare expenses incurred so that you (and your spouse, if married) can work, look for work, or attend school on a full-time basis. Sheakley administers the DDC account and can be reached by calling 800.877.2053 or logging on to https://sheakleycdhee.lh1ondemand.com.

ADDITIONAL BENEFITS AND CONTACT INFORMATION

TELEMEDICINE

Quality care is only a call or click away. U.S. board-certified doctors can resolve many of your medical issues, 24/7 and 365 days a year, via phone or online video consults from wherever you are. Teladoc qualifies as an expense for HSA and FSA accounts and the $45 consult fee applies to your deductible.

Teladoc does not replace your Primary Care Physician (PCP). It is simply another option for when your doctor is not available, especially in the middle of the night or weekends. Teladoc can be used when you need care now, if you are considering the ER or Urgent Care for non-emergent issues or when you are on vacation, a business trip or away from home. Teladoc can even send a prescription to a pharmacy for short-term refills. For more information visit www.teladoc.com or call 800.362.2667.

EMPLOYEE ASSISTANCE PROGRAM

You have access to the Employee Assistance Program (EAP) through Support Linc. Under the EAP, you and your household members are eligible for 6 free counseling sessions (per presenting issue) to speak with a counselor who can help with an assortment of life's matters, such as:

- Managing Depression and Anxiety
- Alcohol/Substance Abuse
- Child and Elder Care Resources
- Legal and Financial Issues
- Grief and Bereavement
- Job Performance
- Family Issues

Professional help through your EAP is available for many other types of problems that may affect your quality of life. To speak with a counselor, or to arrange an appointment call 888.881.LINC (5462) or go to www.supportlinc.com.

AzMT L.I.V.E. –WELLNESS PROGRAM

AzMT offers a comprehensive Wellness Program to all members, AzMT L.I.V.E. (Live. In. Vitality. Everyday.), which focuses on three key categories: Early Detection, Lifestyle Modification, and Disease Management.

Mission Statement - "Support and empower members and their families' healthy lifestyle by providing evidence-based programming. The Wellness Program provides resources that are of value to the individuals it serves so they can thrive in daily life."

Goals of AzMT L.I.V.E.:

- Help improve the quality of life for employees and dependents
- Prevent disease and disability or catch it in early stages
- Reduce the amount of money spent towards medical and prescription claims
- Improve productivity by reducing absenteeism and presenteeism

ALL preventive services required by Health Care Reform are covered 100% for AzMT medical benefit plan members. All onsite AzMT L.I.V.E. programs are also provided at no cost to members.

Wellness/preventive services are all services without signs or symptoms with the intent to prevent illness or disease.

Screenings/Services

Recommended screenings and services are specific to your age and gender which include, but are not limited to:

Adults – Blood Pressure, Cholesterol, Diabetes, HIV, Colorectal Screenings and Immunizations

Women – Mammograms, Cervical Cancer and HPV testing, and some prenatal care and breast-feeding supplies

Children – Immunizations and newborn screenings

Prescription Drugs – Contraceptives, Low Dose Aspirin, Folic Acid, and Iron Supplements

For a listing of all services and prescription drugs covered by Health Care Reform, please visit: www.healthcare.gov/preventive-care-benefits

On-Site Screenings

As a part of AzMT's Wellness Program, some preventive screenings are brought on-site to provide members a convenient and timely way to protect their health.

The following screenings are provided on an annual basis:

- Health Risk Assessments
  - Lifestyle Questionnaire
  - Biometric Data
    - Height, Weight, and Body Mass Index (BMI)
  - Fasting Blood Draw
    - Full Lipid Panel (Cholesterol)
    - Blood Sugar (Diabetes)
    - Optional Thyroid Screening
    - Optional Prostate Specific Antigen (PSA)
- Skin Cancer Screenings
- Cardiac & Organ Screenings
- Mammograms
- Flu and Pneumonia Vaccinations

Please look for wellness emails and flyers throughout the year for screening dates and additional information.

IMPORTANT NOTE: Your Personal Health Information will NEVER be released to your Human Resources/Benefits Department or your employer. Individual data is never used to determine your insurance coverage.

Do you want to keep up to date on the latest wellness events, news and information? Please opt in to our text messaging and email services by contacting your AzMT Wellness Consultant at AzMT@ecollinsandassociates.com.

CUSTOMER SERVICE SUPPORT

If you have specific questions related to your annual enrollment, contact Human Resources at **623.333.2200.**

Need help or have questions about your coverage, claims, etc.? Contact any of the vendors below for assistance.

PLAN CONTACT INFORMATION

Benefit	Phone	Website
Medical Plans – Administered by AmeriBen Eligibility, medical benefits, coverage questions, and ID cards	855.350.8699	www.myamberiben.com
Provider Network – Blue Cross Blue Shield of Arizona Network of hospitals, physicians and other health care providers	877.475.8454	www.azblue.com/CHSnetwork
Prescriptions – Administered by Navitus Prescription claims, coverage questions	866.333.2757	www.navitus.com
Medical Review – AmeriBen Medical Management Medical plan pre-certification, case management, and medical necessity	855.778.9053 Fax 833.730.7961	www.myameriben.com
Employee Assistance Program – Support Linc Confidential counseling for life's matters	888.881.5462	www.supportlinc.com
Dental – Delta Dental of Arizona Dental claims, eligibility and coverage questions	800.352.6132	www.deltadentalaz.com
Vision – VSP Vision claims, eligibility and coverage questions	800.877.7195	www.vsp.com
Life – Minnesota Life Life administration for basic, voluntary life and AD&D	800.392.7295	www.ochsinc.com
Telemedicine – Teladoc Access to US board-certified doctors & pediatricians 24/7/365	800.835.2362	www.teladoc.com
Health Savings Account – Health Equity Account balance, covered expenses, and online claims submissions	866.346.5800	www.healthequity.com
Flexible Savings Account – Sheakley Account balances, covered expenses and reimbursement forms	888.868.3539	www.sheakleycdhee.lh1ondemand.com
Plan Administrator – Erin P. Collins & Associates, Inc. (ECA) Day-to-day administration of AzMT, claims and coverage questions or issues, appeals and general information and assistance	928.753.4700 x302 jaimes@ecollinsandassociates.com	www.azmt.org
Insurance Plan/Information – Arizona Metropolitan Trust	N/A	www.azmt.org

SPECIAL NOTICES

IMPORTANT NOTICE FROM AzMT ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE – YOUR MEDICARE PART D NOTICE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. AzMT has determined that the prescription drug coverage offered under the Exclusive Provider Organization (EPO), and Preferred Provider Organization plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

3. AzMT has determined that the prescription drug coverage offered under the High Deductible Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage**. <u>This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from AzMT. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.</u>

    - You can keep your current coverage from AzMT. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When Can You Join a Medicare Drug Program?

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

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

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

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

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

If you decide to join a Medicare drug plan, your current AzMT coverage will not be affected. Your current AzMT medical coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare drug plan, you will still be eligible to receive medical and prescription drug benefits through AzMT. If you do enroll in a Medicare drug plan, in general, the following guidelines apply:

- If you are an active employee, or the covered dependent of an active employee, you are required to obtain your outpatient prescription drug benefits through your AzMT plan first. You can then file on a secondary basis with your Medicare drug plan.

- If you are a COBRA participant, or the covered dependent of a COBRA participant, you are required to obtain your outpatient prescription drugs through your Medicare drug plan first. Secondary coverage is <u>not</u> available through AzMT.

Important: You can only waive prescription drug coverage by waiving the entire AzMT medical/prescription plan coverage for yourself and your dependents. Remember, if you do waive your AzMT coverage, active employees can only re-enroll in the medical/prescription combined plan during the next Open Enrollment Period.

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

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

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

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

- Visit www.medicare.gov/
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 800.772.1213 (TTY 800.325.0778).

Name of Entity/Sender:	Arizona Metropolitan Trust (AzMT)
Contact Person:	Jaime L. Schulenberg, Pool Administrator
Address:	c/o Erin P. Collins & Associates, Inc. 1115 Stockton Hill Rd., Ste. 101 Kingman, AZ 86401
Phone Number:	928.753.4700 x302

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema. Plan limits, deductibles, copayments, and coinsurance apply to these benefits.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, (including medical plans sponsored by the City) generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefit or out-of-pocket costs so that nay later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your plan provider to pre-certify the extended stay. If you have questions about this Notice, contact AmeriBen at 855.350.8699.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP, and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, 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 dependents are eligible for premium assistance under Medicaid or CHIP, and are eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in a health Plan and receive your Summary Plan Document. You can get another copy of this Notice from the AzMT Plan Administration at 928.753.4700 or at www.azmt.org.

KEEP THE CITY NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your dependents must promptly furnish the City's HR department with information regarding change of name, address, marriage, divorce or legal separation, change in Domestic Partnership status, death of any covered family member, birth or change in status of a dependent child, Medicare enrollment or disenrollment, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan within 31 days after any of the above noted events.

Failure to give the City timely notice of the above noted events may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage;

b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability;

c. cause claims to not be able to be considered for payment until eligibility issues have been resolved; or

d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future [medical, dental, and/or vision] benefits.

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility contact HR at 623.333.2200.