Town of Youngtown

2022-23 Annual Enrollment Benefits Guide

AzMT ARIZONA Metropolitan Trust

ANNUAL ENROLLMENT

IS MAY 01 THROUGH MAY 31, 2022!

Tips & Information

- Contact Administration at 623.933.8286 if you have any questions on health plan benefits
- Enroll or make changes using the Enrollment/Change Form available in your packet or from Administration
- Select the right plans for you. Review the Medical/Rx plan comparison charts (pages 14-16), dental and vision benefits (pages 17-19), and life insurance information (pages 20-21)
- You need to take action during the Annual Enrollment Period **only if you need to make a change**; otherwise your current elections will roll over for the new plan year
- Don't delay – enroll or make your changes on or before May 31, 2022
- Submit any additional required documentation to Administration on or before May 31, 2022
- Detailed benefit plan information and more can be found in this benefits guide or from Administration at 623.933.8286

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 Town benefits, please contact the Town at 623.933.8286

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.

TABLE OF CONTENTS

AS YOU ENROLL

The Town of Youngtown 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, 2022 through June 30, 2023.

This Benefits Guide is designed to help you make informed decisions regarding your benefit elections during the 2022-23 Annual Enrollment period. It highlights your options and key program features to consider before making enrollment elections. You will also find 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, changed your name or changed your contact information, be sure to notify the Town. 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 Administration or the plan providers directly. Plan phone numbers and websites are listed in the Contact Information section on Page 25 of this Benefits Guide.

Medical Plan Options

The Town of Youngtown will continue offering two Medical plans, one Dental and one Vision plan through the Arizona Metropolitan Trust (AzMT) utilizing the BlueCross BlueShield 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)

The two Medical plans 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 from Administration or the AmeriBen website www.myameriben.com.

2022-23 BENEFIT CHANGES

The following benefit changes will be effective July 01, 2022 for all plans:

- Eliminate $20 Co-Pay for On-Site 3D Mammograms
- Add Coverage for At-Home Sleep Studies
  - Requires Pre-Certification
  - Ordered by Medical Provider
- Eliminate Pre-Certification for Colonoscopies
- Add New Teladoc Options
  - Dermatology with $85 Consultation Fee
  - Nutritional Coaching with $59 Consultation Fee

ANNUAL ENROLLMENT PERIOD – May 01 – May 31, 2022

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, 2022 through June 30, 2023, without having a qualifying event.

WHAT CAN I DO DURING THE ANNUAL ENROLMENT PERIOD?

- ✓ Change your medical, dental or vision plan.
- ✓ Add or waive medical and/or dental and vision coverage for you and/or your dependents.
- ✓ Apply for supplemental and/or dependent life insurance. Note: Supplemental life insurance takes effect after approval from Minnesota Life/Securian.
- ✓ You need to take action during the annual enrollment period only if you need to make a change; otherwise your current elections will roll over for the new plan year.

SUBMITTING ANNUAL ENROLLMENT PERIOD ELECTIONS AND DEADLINE

Benefit elections and/or changes to your existing benefits are made via the Enrollment/Change Form which can be found in this Guide or from Administration.

All benefit elections and changes must be submitted to the Town by 4:00 p.m. on Tuesday, May 31, 2022.

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 Town-sponsored medical plan. The Town 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 each of your benefit plans (i.e., medical, dental, vision, and dependent life insurance), 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 CONTINUE MY CURRENT ELECTION?

If you make no changes to your current elections, your current benefits will continue through June 30, 2023. Be aware that making no change is considered an election to retain the benefits currently in place for the upcoming plan year.

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 Administration 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 8-9 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 Enrollment/Change Form and applicable supporting documentation is received by Administration. (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 30 days of employment.

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

If your coverage was terminated or lapsed while on leave, you will need to re-enroll for coverage upon return from your leave. Your coverage will be effective on the first day of the month following your return. If you are returning from a Military leave of absence, your coverage will be effective on the date you return from leave.

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 Enrollment/Change Form to Administration within 31 days of the newborn's date of birth. If enrollment is requested in a timely manner, coverage will be retroactively effective to the date of birth. You are encouraged to request newborn enrollment and submit required documentation 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)
Marriage	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 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)
Significant change in or cost of you 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*
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) days 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 the 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 30 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 Town-sponsored medical, dental and vision plans, your eligible dependents may also participate. Your eligible dependents include:

- Your lawfully married spouse
- You or your spouse's dependents to age 26 for medical and age 19 for dental and vision, 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 age of 26 for medical or 19 for dental and vision, who are considered disabled

Eligible dependent child(ren) will be covered through the last day of the month of their 19th or 26th birthday for dental/vision and medical, respectively.

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 two medical plans will automatically be enrolled in the prescription, wellness program, EAP, and telemedicine benefits which are all included in your premiums. The Town of Youngtown is pleased to offer you the following medical plans:

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

When you enroll in a medical plan, you also decide if you want to enroll your eligible dependents in coverage. You can choose four levels of coverage: Employee Only, Employee + Spouse, Employee + Child(ren), or Employee + Family.

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

AzMT Health Plans

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

BlueCross BlueShield 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 choose. 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.

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.costco.com/home-delivery 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: Covid-19, Influenza, Pneumonia, Tetanus/Diptheria, 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.

CVS

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

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 network, in that you can choose between an in-network group of providers and out-of-network providers. 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. Under the HDHP, you are responsible for payment of all services and prescriptions until you meet your deductible ($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.
- 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 Town 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

2022-23 Plans and Benefits	HDHP		PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible				
Single	$2,900	$5,000	$750	$2,000
Family	$5,800	$10,000	$1,500	$4,000
Plan Year Out-of-Pocket Maximum[1]				
Single	$2,900	$10,000	$3,500	$5,000
Family	$5,800	$20,000	$7,000	$10,000
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%*
Allergy Testing and Treatment	0%*	50%*	20%*	50%*
Hearing Aid Benefit	$1,000**	$1,000**	$1,000**	$1,000**
Genetic Testing (Limitations Apply)	0%*	0%*	20%*	50%*
Ambulance Services	0%*	50%*	20%*	50%*
Chemotherapy (Outpatient)	0%*	50%*	20%*	50%*
Chiropractic Care/Spinal Manipulation	0%*	50%*	$25 Copay	50%*
Plan Year Maximum Benefit	30 Visits		30 Visits	
Diagnostic Testing, X-Ray and Lab Services				
Free Standing Laboratory Facility	0%*	50%*	20%*	50%*
Free Standing Radiology Facility	0%*	50%*	20%*	50%*
All Other Locations (except office visit)	0%*	50%*	20%*	50%*
Durable Medical Equipment (DME)	0%*	50%*	20%*	50%*
Emergency Room	0%*	50%*	$300 Copay + 20%* Copay Waived if Admitted	
Home Health Care	0%*	50%*	20%*	50%*
Plan Year Maximum Benefit	60 Visits		60 Visits	
Hospice Care	0%*	50%*	20%*	50%*
Lifetime Maximum Benefit	6 Months		6 Months	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)				
Inpatient/Outpatient	0%*	50%*	20%*	50%*
Maternity				
First Visit to Confirm Pregnancy				
Primary Care Physician	0%*	50%*	$25 Copay	50%*
Specialist	0%*	50%*	$45 Copay	50%*
Prenatal and Postnatal Care	0%*	50%*	20%*	50%*
Delivery Charges	0%*	50%*	20%*	50%*
Mental Health and Substance Abuse Disorders				
Inpatient	0%*	50%*	20%*	50%*
Outpatient	0%*	50%*	$25 Copay	50%*

Outpatient Therapies (e.g., physical, speech, occupational)	0%*	50%*	20%*	50%*
Plan Year Maximum Benefit	20 Visits		20 Visits	
Physician's Services				
Office Visits				
Primary Care Physician	0%*	50%*	$25 Copay	50%*
Specialist	0%*	50%*	$45 Copay	50%*
Physician Office Surgery				
Primary Care Physician				
Surgery Costing under $500	0%*	50%*	$25 Copay	50%*
Surgery Costing over $500	0%*	50%*	20%*	50%*
Specialist				
Surgery Costing under $500	0%*	50%*	$45 Copay	50%*
Surgery Costing over $500	0%*	50%*	20%*	50%*
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
Radiation Therapy (Outpatient)	0%*	50%*	20%*	50%*
Skilled Nursing Facility and Rehabilitation Facility	0%*	50%*	20%*	50%*
Plan Year Maximum Benefit	60 Days		60 Days	
Urgent Care Facility ~Copay applies per visit regardless of what services are rendered	0%*	50%*	$50 Copay	50%*
All Other Eligible Medical Expenses	0%*	50%*	20%*	50%*

Dual Coverage Reminder… *An eligible employee and his/her eligible dependent(s) Maybe enrolled in a Town-offered medical plan but are allowed only to enroll either as a subscriber in a Town-offered medical plan or, as the dependent spouse of another AzMT entity medical plan or, as the dependent spouse 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 Maximum

PRESCRIPTION PLAN COMPARISON

	HDHP	PPO Plan	HDHP	PPO Plan
	Network Pharmacy		Out-of-Network Benefit	
Plan Year Out-of-Pocket Maximum				
Single	$2,900*	$3,600	$5,000*	$3,600
Family	$5,800*	$7,200	$10,000*	$7,200
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	

***Combined with medical**

CVS is excluded from the pharmacy network.

TOWN CONTRIBUTIONS FOR MEDICAL COVERAGE

You and the Town share in the costs of your medical plan benefits. The plans are funded through the Town'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 Town'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; and
- 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 Town'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.

2022-23 MEDICAL PLAN PREMIUM CHART

	Medical Benefit Costs – Monthly Premium for Benefit Eligible Employees				
	Total Premium	Town Contribution*	Monthly Town HSA Contribution	Employee Contribution	**Per Paycheck
Medical	**HDHP Plan**				
EE - Single	$538.82	$538.82	$25.00	$0.00	$0.00
EE + Spouse	$1,059.15	$824.73	$25.00	$234.42	$117.21
EE + Child(ren)	$974.48	$822.74	$25.00	$151.74	$75.87
EE + Family	$1,440.04	$897.90	$25.00	$542.14	$271.07
	PPO Plan				
EE – Single	$587.88	$587.88	N/A	$0.00	$0.00
EE + Spouse	$1,174.19	$823.07	N/A	$351.12	$175.56
EE + Child(ren)	$1,081.14	$886.75	N/A	$194.39	$97.20
EE + Family	$1,592.90	$992.49	N/A	$600.41	$300.21

DENTAL BENEFITS

Dental is an important part of your benefits package and regular dental care is key to your overall health. The Town 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	**Basic 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/Onlays	50%*	40%*
Prosthodontic/Prosthetics	50%*	40%*
Implants	50%*	40%*
Orthodontics (Adult & Child)	50%	50%
Dental Benefit Maximums		
Maximum Payable Per Plan Year	$2,000 per Person	
Lifetime Orthodontic Benefit	$2,000 per Person	
Child(ren) Age Eligibility	Age 19	

*Applies after deductible

2022-2023 DENTAL PREMIUMS

2022-2023 Dental Premium Rates				
	Total Monthly Premium	Town Contribution	Employee Contribution	* Per Paycheck
	$2,000 Plan			
EE – Single	$40.96	$40.60	$0.36	$0.18
EE + Spouse	$78.86	$45.30	$33.56	$16.78
EE + Child(ren)	$88.27	$46.78	$41.49	$20.75
EE + Family	$130.16	$49.26	$80.90	$40.45

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.

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 WellVision 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	Basic
Copay Eye Exam	$10
Copay Contact Lens Exam	Up to $60
Copay Prescription Glasses (Frames & Lenses)	$20
Frame Allowance	$150 Allowance $170 for Featured Frame Brands 20% Savings on Amounts Over Allowance $80 Costco Frame Allowance
Lenses	Single Vision, Lined Bifocal and Lined Trifocal Impact-Resistant Lenses for Children
Lens Enhancements	Standard Progressive Lenses - $0 Premium Progressive Lenses - $95 - $105 Custom Progressive Lenses - $150 - $175
Contact Lenses (In Lieu of Lenses/Frames) per Plan Year	$150 Allowance
Frequency	Every Plan Year
Child(ren) Age Eligibility	Age 19

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.

2022-2023 VISION PREMIUMS

2022-2023 Vision Premium Rates				
	Total Monthly Premium	Town Contribution	Employee Contribution	Per Paycheck Employee Contribution
EE – Single	$7.27	$7.27	$0.00	$0.00
EE + Spouse	$16.02	$16.02	$0.00	$0.00
EE + Child(ren)	$14.13	$14.13	$0.00	$0.00
EE + Family	$22.77	$22.77	$0.00	$0.00

LIFE INSURANCE

BASIC AND SUPPLEMENTAL LIFE INSURANCE

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

	Basic Life and AD&D Insurance 100% Paid by the Town	**Supplemental Life Employee Paid**
Employee	$50,000	Increments of $10,000 up to a total of $750,000

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 $250,000, your spouse up to $30,000 and your child(ren) $15,000.

During annual enrollment

- 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 $50,000 without evidence of insurability; if you request more than $50,000 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 $50,000 without evidence of insurability.** Any other level of coverage you elect is subject to approval by Minnesota Life/Securian 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/Securian.

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 rates for each $1,000 in supplemental 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 $0.80 per pay period

2022-2023 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 total life insurance amounts. Child(ren) can be covered in increments of $2,500 up to $15,000, not to exceed 100% of employee's Basic and Supplemental amount.

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 $0.65 per pay period

All children receive a $10,000 benefit.

2022-2023 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 you need more protection than the Town-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 updated (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 HEALTH 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 High-Deductible Health Plan (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 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), are enrolled in an FSA, or are enrolled in Medicare.

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 2022 maximum contribution for single coverage is $3,650, and family is $7,300. HSA participants who are 55 or older can contribute an additional $1,000, or $4,650 for single coverage and $8,300 for family coverage. The Town of Youngtown 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, 2022 - December 31, 2022; 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

*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 considered income for tax purposes.

How do I qualify 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 an 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.
- The general rule is an individual is ineligible to make HSA contributions for a month if he/she receives Veteran's Affairs (VA) benefits at any time in the previous 3-months; Preventive care benefits from the VA will not disqualify an otherwise HSA eligible individual.

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.

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 $50 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.

Dermatology – Teladoc doctors can provide treatment for many common skin problems including acne, rash, poison ivy, eczema, skin infections, ringworm, athlete's foot, lice, shingles, etc. Simply take up to five (5) photos of the issue and send to Teladoc. You will receive a response within 48 hours. Members will pay an $85 per consult.

Nutritional Coaching – Tealdoc offers registered dieticians to assess and provide advice regarding nutrition, including a personalized nutrition guide and various support tools. These services are available to members as well as dependents under 18 with adult supervision for a $59 consultation fee.

EMPLOYEE ASSISTANCE PROGRAM

You have access to the Employee Assistance Program (EAP) through SupportLinc. 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; and
- 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 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 service by contacting your AzMT Wellness Consultant Kingman.GBS.ArizonaMetropolitan@ajg.com.

CUSTOMER SERVICE SUPPORT

Need help or have questions about your coverage, claims, etc.? Contact any of the vendors below for assistance. If you have specific questions related to your annual enrollment, contact Administration.

E-mail: jblackman@youngtownaz.org

Phone: 623.933.8286

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	855.894.9627	www.teladoc.com
Health Savings Account– Health Equity Account balance, covered expenses, and online claims submissions	800.835.2362	www.healthequity.com
Plan Administrator – Gallagher Day-to-day administration of AzMT, claims and coverage questions or issues, appeals and general information and assistance	928.391.2297 jaime_schulenberg@ajg.com	

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you've been wrongly billed you may contact the No Surprises Help Desk (NSHD) at http://www.cms.gov/nosurprises or call 800.985.3095for more information about your rights under federal law.

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 two 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 all of its plans, the Preferred Provider Organization (PPO) and the High Deductible Plan (HDHP) 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 this 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.

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 Gallagher 1115 Stockton Hill Rd., Ste. 101 Kingman, AZ 86401
Phone Number:	928.391.2297

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you 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.

This coverage is subject to the same deductibles and co-payments consistent with those established for other benefits under your plan.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT NOTICE

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., the Member's physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any 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, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). Pre-certification is still required for the delivery and for newborn placement in an intensive care nursery. Pre-certification is also required for any length of stay period in excess of the minimum (48 or 96 hours), even though not required for the minimum length of stay period.

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid (AHCCCS in Arizona) or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid (AHCCCS) or CHIP, you can contact the Arizona Medicaid (AHCCCS) or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid (AHCCCS) or CHIP, and you think you or any of your dependents might be eligible for either of these programs you can contact:

ARIZONA – CHIP
http://www.azahcccs.gov/
602-417-5422

1-877-KIDS NOW
www.insurekidsnow.gov

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid (AHCCCS) or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

To research the availability of, and your eligibility for, premium assistance in other states, please contact the following agencies:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

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 928.391.2297.

KEEP THE TOWN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your dependents must promptly furnish the Town's Administration department with information regarding change of name, address, marriage, divorce or legal separation, 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 Town timely notice of the above noted events April:

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 the Town at 623.933.8286.