Employee Benefit Guide

AZMT ARIZONA Metropolitan Trust

July 1, 2024 – June 30, 2025

AzMT ARIZONA Metropolitan Trust

Annual Enrollment is April 15 through April 25, 2024

TIPS AND IMPORTANT INFORMATION

- All employees will need to take action in Munis Employee Self Service (ESS) during the Annual Enrollment Period, to confirm no changes in current benefits or in selecting new coverage options.
- Effective July 1, 2024, only Medical Flexible Spending Account (FSA) will be offered. Employees must enroll in this FSA annually.
- Select the plans that are right for you. Review the Medical/Rx plan comparison charts (pages 5-10), dental and vision benefits (page 13-15), and life insurance information (pages 16-18)
- Don't delay – enroll or make your changes on or before 5:00 p.m. April 25
- Submit any additional required documentation to HR by 5:00 p.m. April 25
- All enrollment documents must be submitted electronically here: https://cityofapachejunctionaz.munisselfservice.com/default.aspx
- Detailed benefit plan information and more can be found in this Plan Document(s).
- Contact Human Resources via email at webmailhr@apachejunctionaz.gov or call 480.474.2617, if you have benefit questions.

2024-25 BENEFIT CHANGES

- Medical
  - Increase the HDHP In-network Deductible and Max Out-Of-Pocket from $3,000/$6,000 to $3,200/$6,400
- Dental
  - Change Bitewing X-Rays to 1x/year;
  - Allow 3 Cleanings per year for all participants; and
  - Add Special Healthcare Needs Program.
- Vision
  - Add Blue Light Care to both the Basic and Buy Up Plans
  - Add Easy Options to both the Basic and Buy Up Plans
- Other
  - Add Sword Digital Physical Therapy and Bloom Pelvic Health Program

TABLE OF CONTENTS

This Benefit Guide gives you an overview of your benefits including eligibility, plan options, rate, 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 the City's intranet page and click the Human Resources tab.

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

The benefits and premium costs contained in this Benefits Guide are effective July 01, 2024 through June 30, 2025.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 31 for more details.

About Your Benefits

At the City of Apache Junction we are committed to providing a comprehensive and valuable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your benefits. If you have any questions, feel free to reach out to Human Resources at **480.474.2617** or email at webmalhr@apachejunctionaz.gov.

Eligibility and Enrollment

You are eligible to participate in the City of Apache Junction benefits if you are a full-time employee working at least 30 hours per week. If you enroll for benefits, you may also cover your:

- Legal spouse
- Children up to age 26
- Unmarried children of any age who are mentally or physically disabled

Your benefits begin on the first of the month following 30 days of employment.

Select Your Benefits Carefully

To get the most value from your benefits, carefully consider which options are right for you and your family. Because premiums for certain benefits are deducted on a pre-tax basis, IRS regulations may prohibit you from making enrollment changes until the end of the plan year, unless you experience a qualifying event. Pre-tax benefits include: Medical, Dental, Vision, FSA and HSA (HDHP only).

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during Annual Enrollment. Any pre-tax benefit elections made during open enrollment must remain in effect until the following Annual Enrollment period, unless you experience a qualifying event which may allow for a mid-year election change. Examples of qualifying events include:

- Marriage, legal separation or divorce;
- Birth or adoption of a child;
- Change in a dependent's eligibility status;
- Loss of eligibility for group health coverage, health insurance coverage, or Medicaid/CHIP; and/or
- Becoming eligible for a state premium assistance subsidy.

If you believe you have a qualifying event please notify Human Resources immediately. You have 31 days from the date of a qualified change in status to make changes. However, note that if you lose eligibility for Medicaid/CHIP, or become eligible for a state premium assistance subsidy, you have 60 days from that qualified change in status to make changes. Keep in mind, the changes you make must be directly related to the event.

Medical Coverage

Terms to Know

- **Copay** - A set dollar amount you pay for a covered healthcare service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for healthcare services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered healthcare services after you reach the deductible. You pay a percentage of the cost, and the medical plan pays the rest.
- **Out-of-Pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide healthcare services. In-network providers typically provide services at a lower negotiated rate. If you receive services from a provider that is **In-Network** it will cost you significantly less than going to a provider that is **Out-of-Network.**
- **Formulary Drug List:** A drug formulary is a list of generic and brand-name drugs that have been evaluated for safety and effectiveness and are covered under the AzMT plans.
- **Generic Drugs**: Identical or –bioequivalent- to a brand name drug in dosage, form, safety, strength, route of administration, quality, performance characteristics and intended use.
- **Brand Name Drugs:** Sold by drug companies under a specific name or trademark and are protected by patent.
- **Specialty Drugs:** Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you will be required to use the specialty pharmacy. Register by logging in to www.Navitus.com.

How the Plans Work

All plans use the Blue Cross Blue Shield of Arizona network and cover 100% of the cost for in-network preventive care services covered under Health Care Reform like annual physicals and routine immunizations. The way you pay for care is different with each plan.

PPO: This Plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible ($750/$1,500 In-Network $2,000/$4,000 Out-of-Network), so you will pay copays until you reach your annual out-of-pocket maximum ($3,500/$7,000 In-Network/$5,000/$10,000)Out-of-Network).

PPO Buy-Up: This Plan has set copays for some services and a deductible and co-insurance for others. Copays do not apply toward your deductible ($250/$500 In-Network $500/$1,000 Out-of-Network), so you will pay copays until you reach your annual out-of-pocket maximum ($3,000/$6,000 In-Network/$5,000/$10,000 Out-of-Network).

HDHP (High Deductible Health Plan): You pay the full negotiated cost for medical services and prescription drugs until you meet your annual deductible ($3,200/$6,400 In-Network/$5,000/$10,000 Out-of-Network). Once you meet your deductible, your eligible in-network claims will be paid at 100% for the rest of the plan year; once you meet your out-of-network deductible, you will pay 50% of eligible claims until you reach your maximum out-of-pocket ($10,000/$20,000).

Each of these plans offer 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. Keep in mind that if you choose out-of-network providers you will be subject to a higher cost and the provider can balance bill you.

Blue Cross Blue Shield of Arizona (BCBSAZ) is the network provider and plan members have access to more than 25,100 doctors and specialist that make up a strong Arizona network. BCBSAZ has contracted with more than 95% of hospitals in Arizona, including 80 acute cared 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 Medicare Like Rate and the provide can balance bill you, potentially leaving your with thousands of dollars owed out-of-pocket.

AmeriBen is the Third-Party Claim 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; 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.

PPO Plan		
	IN-NETWORK	NON-NETWORK
Deductible (Individual/Family)	$750/$1,500	$2,000/$4,000
Coinsurance	20%	50%
Out-of-Pocket Maximum (Individual/Family)	$3,500/$7,000	$5,000/$10,000
Pharmacy Out-of-Pocket Maximum	$3,600/$7,200	
BASIC & PHYSICIAN CARE		
Preventive Care	$0	Not Covered
Primary Care Office Visit	$25 co-payment /visit, deductible waived	50% co-insurance after deductible
Specialist Office Visit	$45 co-payment /visit, deductible waived	50% co-insurance after deductible
Virtual Visits	Same as Office Visit	
Diagnostic Lab*/X-Ray	20% co-insurance after deductible *No Charge when labs are received in a free-standing facility	50% co-insurance after deductible
Imaging (MRI/CT/Pet Scans, Etc.)	20% co-insurance after deductible	50% co-insurance after deductible
SICK AND QUICK CARE		
Urgent Care Facility	$50 co-pay/visit, deductible waived	50% co-insurance after deductible
Emergency Room	$300 co-payment/visit, plus 20% co-insurance after deductible	
HOSPITALIZATION		
Inpatient Hospital	20% co-insurance after deductible	50% co-insurance after deductible
Outpatient Surgery	20% co-insurance after deductible	50% co-insurance after deductible
PHARMACY		
Generic Drugs	$15 co-payment (30-day supply) $30 co-payment (90-day supply)	You pay the network pharmacy co-payment plus the difference between the non-network and network pharmacy cost.
Preferred Brand Drugs	$35 co-payment (30-day supply) $80 co-payment (90-day supply)	
Non-Preferred Brand Drugs	$55 co-payment (30-day supply) $130 co-payment (90-day supply)	
Specialty Drugs	20% co-payment to maximum of $300/30-day supply	

Finding In-Network Workers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to www.azblue.com/CHSNetwork or call the number on your Member ID Card to find providers in the BCBSAZ network.

PPO Buy-Up Plan		
	IN-NETWORK	NON-NETWORK
Deductible (Individual/Family)	$250/$500	$500/$1,000
Coinsurance	20%	50%
Out-of-Pocket Maximum (Individual/Family)	$3,000/$6,000	$5,000/$10,000
Pharmacy Out-of-Pocket Maximum	$4,100/$8,200	
BASIC & PHYSICIAN CARE		
Preventive Care	$0	Not Covered
Primary Care Office Visit	$25, copayment/visit, deductible waived	50% co-insurance after deductible
Specialist Office Visit	$45, co-payment/visit, deductible waived	50% co-insurance after deductible
Virtual Visits	Same as Office Visits	
Diagnostic Lab*/X-Ray	20% co-insurance after deductible *No Charge when labs are received in a free-standing facility	50% co-insurance after deductible
Imaging (MRI/CT/Pet Scans, Etc.)	20% co-insurance after deductible	50% co-insurance after deductible
SICK AND QUICK CARE		
Urgent Care Facility	$50 co-pay/visit, deductible waived	50% co-insurance after deductible
Emergency Room	$300 co-payment/visit, plus 20% co-insurance after deductible	
HOSPITALIZATION		
Inpatient Hospital	20% co-insurance after deductible	50% co-insurance after deductible
Outpatient Surgery	20% co-insurance after deductible	50% co-insurance after deductible
PHARMACY		
Generic Drugs	$15 co-payment (30-day supply) $30 co-payment (90-day supply)	You pay the network pharmacy co-payment plus the difference between the non-network and network pharmacy cost.
Preferred Brand Drugs	$35 co-payment (30-day supply) $80 co-payment (90-day supply)	
Non-Preferred Brand Drugs	$55 co-payment (30-day supply) $130 co-payment (90-day supply)	
Specialty Drugs	20% co-payment to maximum of $300/30-day supply	

Finding In-Network Providers

You save the most money when you choose in-network doctors, facilities and Pharmacies. Log on to www.azblue.com/CHSNetwork or call the number on your Member ID Cards to find providers in the BCBSAZ network.

HDHP		
	IN-NETWORK	NON-NETWORK
Deductible (Individual/Family)	$3,200/$6,400	$5,000/$10,000
Coinsurance	N/A	50%
Out-of-Pocket Maximum (Individual/Family)	$3,200/$6,400	$10,000/20,000
BASIC & PHYSICIAN CARE		
Preventive Care	$0	Not Covered
Primary Care Office Visit	No Charge after deductible	50% co-insurance after deductible
Specialist Office Visit	No Charge after deductible	50% co-insurance after deductible
Virtual Visits	Same as Office Visits	
Diagnostic Lab/X-Ray	No Charge after deductible	50% co-insurance after deductible
Imaging (MRI/CT/Pet Scans, Etc.)	No Charge after deductible	50% co-insurance after deductible
SICK AND QUICK CARE		
Urgent Care Facility	No Charge after deductible	50% co-insurance after deductible
Emergency Room	No Charge after Deductible	
HOSPITALIZATION		
Inpatient Hospital	No Charge after deductible	50% co-insurance after deductible
Outpatient Surgery	No Charge after deductible	50% co-insurance after deductible
PHARMACY		
Generic	No Charge after deductible	The amount payable in excess of the amounts shown to the left will be the difference between the non-network and network pharmacy cost.
Preferred brand drugs	No Charge after deductible	
Non-Preferred brand drugs	No Charge after deductible	
Specialty Drugs	No Charge after deductible	

Finding In-Network Providers
You save the most money when you choose in-network doctors, facilities and Pharmacies. Log on to www.azblue.com/CHSNetwork or call the number on your Member ID Cards to find providers in the BCBSAZ network.

Employee Medical Costs.

HDHP Plan				
Coverage Tier	Total Premium	City Monthly Contribution	Employee Monthly Contribution	Per Pay Period
Employee Only	$574.51	$553.94	$20.57	$10.29
Employee + Spouse	$1,135.37	$866.72	$268.65	$134.33
Employee + Child(ren)	$1,044.61	$817.74	$226.87	$113.44
Employee + Family	$1,543.80	$1,091.11	$452.69	$226.35

PPO Plan				
Coverage Tier	Total Premium	City Monthly Contribution	Employee Monthly Contribution	Per Pay Period
Employee Only	$629.77	$568.22	$61.55	$30.78
Employee + Spouse	$1,257.99	$915.75	$342.24	$171.12
Employee + Child(ren)	$1,158.33	$861.52	$296.81	$148.41
Employee + Family	$1,706.67	$1,161.45	$545.22	$272.61

PPO Buy-Up Plan				
Coverage Tier	Total Premium	City Monthly Contribution	Employee Monthly Contribution	Per Pay Period
Employee Only	$643.91	$569.67	$74.24	$37.12
Employee + Spouse	$1,287.79	$925.63	$362.16	$181.08
Employee + Child(ren)	$1,185.22	$869.77	$315.44	$157.72
Employee + Family	$1,749.28	$1,176.94	$572.34	$286.17

Health Savings Accounts (HSA)

Administered by Health Equity

An HSA is a savings account that allows you to pay for qualified medical expenses by setting aside money on a pre-tax basis from your paycheck. The money in your account accumulates on a tax-deferred basis and can be rolled over from year to year.

	Health Savings Account (HSA)
What medical plan MUST I choose?	High Deductible Health Plan (HDHP)
Who administers the HSA ?	Health Equity https://my.healthequity.com
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses). https://www.irs.gov/pulications/p969/
When can I use the funds?	Funds are available as you contribute to the account
Can I roll over funds each year?	Yes, funds roll over from year to year and are yours to keep (even if you leave the City or retire)
How do I pay for eligible expenses?	With your Health Equity debit card
How much can I contribute each year?	$4,150 for individual coverage or $8,300 for family coverage in 2024. You may contribute additional funds to your HSA ($1,000 per tax year) if you will be 55 years or older by December 31 Learn more at: https://my.healthequity.com

Note: If you are enrolled in a non-HDHP, Medicare, Medicaid or Tricare, General Purpose Health Flexible Spending Account, Health Reimbursement Arrangement or claimed as someone else's tax dependent, by law you are not allowed to contribute to an HSA.

What Are the Tax Implications of an HSA?

Contributions to your HSA reduce your taxable income and funds used to pay for qualified medical expenses are never taxed. All money set aside in an HSA grows tax-deferred until age 65, when funds can be withdrawn for any non-medical purpose at ordinary tax rates, or tax-free when used for qualified medical expenses.

Flexible Spending Accounts (FSA)

Administered by Health Equity

Flexible Spending Accounts (FSAs) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and your family.

	Health Care FSA
What is it?	An account that allows you to set aside pre-tax dollars from each paycheck to pay for eligible medical, dental and vision expenses
What expenses are eligible?	You can use the funds to pay for qualified expenses such as: copayments, coinsurance, prescriptions, dental expenses, vision expenses, etc.. www.irs.gob/publications/p502/index.html/
When can I use the funds?	All of the funds you elect are available on the first day of the plan year
How do I pay for eligible expenses?	With your Health Equity debit card
How much can I contribute each year?	You may contribute up to $3,200 to your healthcare FSA . This runs on a plan year basis.

How do I use it?

You must enroll in the FSA program within 31 days of your eligibility date or during annual open enrollment at which time you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit https://my.healthequity.com to access the online portal.

"Use it or Lose it" Rule

The health care FSA runs on a plan year basis. The current plan year is from July 1, 2024 through June 30, 2025. Claims for reimbursement may only be made for services/expenses incurred during the 2024-25 plan year. Be conservative when making elections. Please refer to your plan documents for additional information.

All claims for reimbursement MUST be submitted no later than 90-days after the Plan Year. **Any funds left unclaimed after that date will be forfeited.**

Dental Coverage

Administered by Delta Dental

Good oral care enhances overall physical health and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the dental benefit plan.

	Basic Plan	Buy Up Plan
Annual Deductible (Individual/Family)	$50/$150	$50/$150
Annual Maximum (Per Person)	$2,000	$4,000
Preventive Care (Routine Cleaning and X-rays)	100%	100%
Basic Services (Fillings, Basic Root Canals)	80% after deductible	80% after deductible
Major Services (Extractions, Crowns)	50% after deductible	50% after deductible
Orthodontia	50% (No age limit)	50% (No age limit)
Orthodontia Lifetime Maximum (Per Person)	$2,000	$2,000
Child(ren) Eligibility	Up to Age 19	Up to Age 26

**Applies after deductible*

Employee Dental Costs

Coverage Tier	Total Premium	City Monthly Contribution	Employee Monthly Contribution	Per Pay Period
Basic				
Employee Only	$40.96	$40.96	$0.00	$0.00
Employee + Spouse	$78.86	$60.21	$18.65	$9.33
Employee + Child(ren)	$88.27	$64.69	$23.58	$11.79
Employee + Family	$130.16	$86.44	$43.72	$21.86
Buy-Up				
Employee Only	$42.41	$41.03	$1.38	$0.69
Employee + Spouse	$81.80	$60.30	$21.50	$10.75
Employee + Child(ren)	$96.07	$65.08	$30.99	$15.00
Employee + Family	$141.80	$87.02	$54.78	$27.39

Finding In-Network Dentists

You will pay less for services when you use a dentist in the Delta Dental network. You can find an in-network dentist by visiting **www.deltadetalaz.com** or calling **800.352.6132**.

Vision Coverage

Administered by Vision Service Plan (VSP)

VSP's vision plan covers routine eye exams and helps you pay for glasses or contact lenses. Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages.

	Basic	Buy Up
Eye Exam (Once every fiscal year)	$10 co-pay	$10 co-pay
LENSES (Once every fiscal year)		
Prescription Glasses	$20 co-pay	$10 co-pay
Lenses	Single Vison, Lined Bifocal and Lined Trifocal lenses Impact-Resistant Lenses for Children	Single Vision, Lined Bifocal and Lined Trifocal lenses
Lens Enhancements	Standard Progressive $0 Premium Progressive $95-$105 Custom Progressive $150-$175	Standard progressive $0 Impact-Resistant $0 Premium Progressive and Custom Progressives $25
FRAMES (Once every fiscal year)		
Frame Allowance	$150 allowance $170 for Featured Frames (20% off Remaining Balance) $150 Walmart/Sam's Club Frames $80 Costco Frames	$225 allowance $245 for Featured Frames (20% off Remaining Balance) $225 Walmart/Sam's Club Frames $120 Costco Frames
CONTACT LENSES (Once every fiscal year)		
Allowance for Contacts(in lieu of Lenses/Frames)	$150	$175
Contact Lens Exam (Fitting and Evaluation	Up to $60	Up to $60
Child(ren) Eligibility	Up to Age 19	Up to Age 26

VSP – EASY OPTIONS & LIGHTCARE

This benefit is included for both the Basic and Buy-up plans for each employee and covered dependents when they visit their VSP Network doctor.

The Easy Option program allows each covered employee and dependent to choose **one (1)** upgrade per plan year as outlined below:

*Frame Allowance	$250
*Contact Allowance	$250
*Anti-Reflective Coatings	Covered in Full
*Photochromic Lenses	Covered in Full
*Progressive Lenses	Covered in Full

The Lightcare program allows each covered employee and dependent to add ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses. This is included for Prescription Glasses as well with an allowance of $225 per plan year.

VSP Extras – Hearing Aids

Save up to 60% on 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:

- One year of follow-up visits for fittings, adjustments and cleanings;
- 60-day trial;
- 3-year manufacturer warranty for repairs and one-time loss and damage replacement; and
- 80 free batteries per hearing aid for non-rechargeable models.

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

Employee Vision Costs

Coverage Tier	Employee Paid	Per Pay Period
	Base Plan	
Employee Only	$8.30	$4.15
Employee + Spouse	$18.54	$9.27
Employee + Child(ren)	$16.33	$8.17
Employee + Family	$26.44	$13.22
	Buy Up Plan	
Employee Only	$12.26	$6.13
Employee + Spouse	$27.47	$13.74
Employee + Child(ren)	$25.46	$12.73
Employee + Family	$41.37	$20.69

Finding In-Network Eye Doctors

You can find an in-network eye doctor in the VSP network by visiting **www.vsp.com** or calling 1-800-877-7195 .

Basic Life, Accidental Death & Dismemberment and Supplemental Life Insurance

Administered by Ochs

Minnesota Life/Securian provides Basic Life, Accidental Death and Dismemberment (AD&D), and Supplemental Life insurance to eligible employees. All benefit eligible employees are automatically enrolled in the BasicLife/AD&D insurance coverage and may purchase Supplemental Life insurance. 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 City	Supplemental Life Insurance
Employee	1x annual salary up to $150,000 Maximum	Increments of $10,000 up to Combined Total of $750,000
Dependent Life Package	$2,000 spouse and $1,000 children	Spouse – Increments of $5,000 up to $250,000 (Not to Exceed Employee's Total Basic and Supplemental Coverage) Child(ren)– Increments of $2,500 to $10,000 or $15,000 (One Premium Insures all Children from Live Birth to Age 26)
AD&D	1x Annual Salary up to $150,000	Increments of $10,000 up to $500,00

IMPORTANT: An Evidence of Insurability (EOI) form must be submitted and approved by the carrier if:

- You are electing an amount over the Guarantee Issue (GI). The Guarantee Issue amounts are $250,000 for an employee, $30,000 for a spouse and $15,000 for your child(ren).
- Coverage is available up to the Guarantee Issue limit without answering medical questions if you enrolled when you were initially eligible. If you didn't sign up when you were initially eligible you may have to answer medical questions to obtain this coverage.
- Please Note: If you are required to complete a medical questionnaire, you will be notified by HR.

Coverage will not be available until Minnesota Life/Securian provides approval.

Keep Your Beneficiaries Up to Date

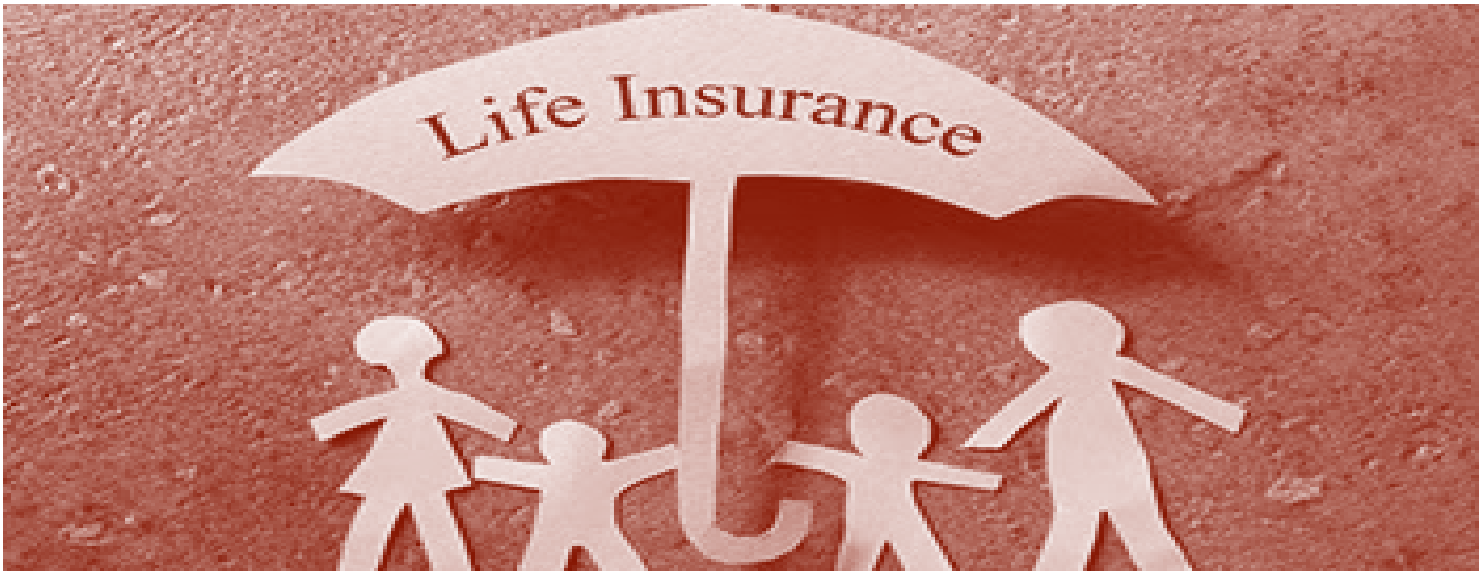
❖ Make sure to keep this information updated so your benefit is paid according to your wishes.

❖ This may be done by completing a Beneficiary Designation form with your employer.

Supplemental Life/AD&D

Supplement Life insurance is available to employees who want to add additional life insurance for themselves or their dependents. Employees can be covered in increments of $10,000 up to $750,000. A spouse can be covered in increments of $5,000 up to $250,000 but cannot exceed the employee's combined Basic and Supplemental life insurance amounts. Child(ren) can be covered in increments of $2,500 up to $15,000.

Voluntary AD&D Provides additional financial protection in the insured's death is due to a covered accident whether it occurs at work or elsewhere. Employees may elect up to $500,00 in increments of $10,000. Dependent AD&D is a percentage of the employee's amount-Spouse with Child(ren) = 40%, Spouse = 50%, Each child with Spouse = 10% or Each child = 15%.



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 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.

Line of Duty Coverage

If a loss is incurred while a public safety officer is taking action that by rule, regulation, law or condition of employment they are obligated or authorized to perform, they will receive an additional Accidental Death & Dismemberment (AD&D) payout in the amount of the lesser of $100,000 or 100% of the employee's current AD&D amount.

Supplemental Life and AD&D Rates

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 in the chart at the bottom of the page.

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.

The cost of Child(ren)'s Term Life is a flat $.013 x 10.

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.

Rates for Voluntary AD&D are $.030/$1,000 for Employee Only coverage and $.045/$1,000 for Employee+Family coverage.

Example: Employee with three children interested in $100K of Voluntary AD&D:

$.045 x 100 = $4.50 per month or $2.25 per pay period

Each child would receive a $15,000 benefit.

Rates (Per $1,000 / Mo)			
Age:	Supplemental	Spouse Rate	Child
0-25	$0.060	$0.049	$0.13 per $1,000 and one premium covers all children enrolled and the benefit payable is for each child.
25-29	$0.060	$0.049	
30-34	$0.080	$0.050	
35-39	$0.090	$0.066	
40-44	$0.124	$0.093	
45-49	$0.201	$0.141	
50-54	$0.307	$0.214	
55-59	$0.496	$0.356	
60-64	$0.660	$0.538	
65-69	$1.270	$0.914	
70-74	$2.060	$1.624	
75*	$7.532	$3.340	

*Rates beyond age 75 are available upon request

Additional Benefits

Telemedicine

Getting to the doctor when you're sick is never easy. That's why Teladoc offers telemedicine for non-emergency care. You can connect with a U.S. board-certified medical professional by phone or video chat. The following copayments are applied for each plan as follows: PPO and PPO Buy-Up $25, and HDHP $55. For further details visit www.Teladoc.com.

Employee Assistance Program

All benefit eligible employees are provided with an employer paid Employee Assistance Program (EAP) through Supportlinc. All eligible employees are automatically enrolled in the EAP.

Life is full of challenges and sometimes balancing it is difficult. The EAP is there when you need it. Supportlinc offers the appropriate assistance for a wide range of issues such as:

- Stress, depression, anxiety;
- Relationship issues, divorce;
- Job stress, work conflicts;
- Family and parenting problems;
- Financial and Legal information;
- Anger, grief and loss, and more

All members of your household can utilize the benefits of this program.

Help is easy to access:

- **Online/phone support**: Unlimited, confidential, 24/7.
- **In-person:** You can get up to **6** visits, per presenting issue, with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

Toll-free 24/7 Access: **1-888-881-5462**
Online Access: **www.supportlinc.com**

Get started!

supportlinc.com
Group code: azmt

Download the mobile app today!

supportlinc
EMPLOYEE ASSISTANCE

PRE-CERTIFICATION LIST EFFECTIVE JULY 01, 2024

As you may be aware, Arizona Metropolitan Trust has contracted with AmeriBen to provide medical management services. Those services include pre-certification and case management. For your information, the list of services that require pre-certification are as follows:

- Inpatient Admissions (surgical and non-surgical [excluding routine newborn deliveries], long term acute care, skilled nursing/rehabilitation facility, inpatient mental health/substance use disorder treatments including residential facilities);
- Inpatient and outpatient surgery including pain management injections and intra-articular hyaluronic acid injections (excluding office surgeries and all colonoscopies/sigmoidoscopies);
- Advanced imaging (CT studies, Coronary CT angiography, MRI/MRA,, nuclear cardiology, nuclear medicine and PET scans, excluding services rendered in an ER setting);
- Outpatient rehabilitation services (physical, occupational and speech therapy) in excess of twenty (20) visits per benefit year per therapy type;
- Chemotherapy drugs/infusions and radiation treatments for oncology diagnoses;
- Home health care services and supplies;
- Transplants (other than cornea) including, but not limited to, kidney, liver, heart, lung, pancreas and bone marrow replacement to stem cell transfer after high dose chemotherapy;
- Orthotics/Prosthetics over $3,000; Durable Medical
- Equipment over $3,000;
- Genetic/genomic testing (excluding amniocentesis) in excess of $1,000;
- Clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition;
- Non-emergent air ambulance;
- Intensive outpatient program in excess of twenty (20) visits per benefit year for mental health and substance use disorder treatment;
- Partial hospitalization in excess of twenty (20) visits per plan participant per benefit year;
- Pre-natal testing;
- Specialty infusion/injectable medications over $3,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an outpatient facility, physician's office, or home infusion); and
- Dental services required for medical procedures.

REMEMBER, FAILURE TO PRE-CERTIFY WILL RESULT IN A $300 PENALTY!

If you have any questions regarding pre-certification, please call AmeriBen at 855.778.9053

Wellness Program Overview

AzMT offers a comprehensive Wellness Program, AzMT L.I.V.E. (Live. In. Vitality. Every day.), to all members which focuses on early detection, lifestyle modification, and disease management. Below is a brief overview of major program offerings available to AzMT medical benefit plan members.

EARLY DETECTION THROUGH PREVENTIVE SCREENINGS

Preventive and early detection screenings are brought onsite to provide members a convenient and timely way to protect their health including, but not limited to, the following:

- Health Risk Assessment
- Skin Cancer Screenings
- Cardiac and Organ Screenings
- Mammograms
- Flu vaccinations

SWORD - DIGITAL PHYSICAL THERAPY

NEW!

Digital Physical Therapy
Movement is medicine. Sword uses sensor technology to deliver a physical therapy program that can be done anywhere, anytime. All the movement data is then shared with your paired physical therapist, who adapts the program based on actual performance.

Bloom
Bloom is a new, digital pelvic-therapy solution that can help women who have suffered from urinary leaking, bowel disorders, pelvic pain, and more. Bloom can be for women in all stages of life including pregnancy, postpartum and menopause.

WELLNESS PORTAL THROUGH VIRGIN PULSE

Virgin Pulse is a wellness portal designed to help you track your healthy habits, create new ones, learn about health topics that are important to you, and much more! By engaging in the portal, you earn points that can be redeemed for big rewards.

Members can earn up to $100 every year!

Use these rewards to shop in the Virgin Pulse Store. Sign up using the link: join.virginpulse.com/AzMT or scan the QR code!

MONTHLY NEWSLETTER

Each month AzMT offers a free digital wellness newsletter that includes health information and upcoming events in the L.I.V.E. wellness program.

Opt-in to the newsletter by scanning the QR code or using the link below. Members can sign up with the email of their choice.

AzMT Wellness Newsletter Sign up link:
https://lp.constantcontactpages.com/sl/U6vbW0O/azmtnewsletter

For questions, please reach out to your Human Resources Department.

AzMT ARIZONA Metropolitan Trust

AzMT L.I.V.E.

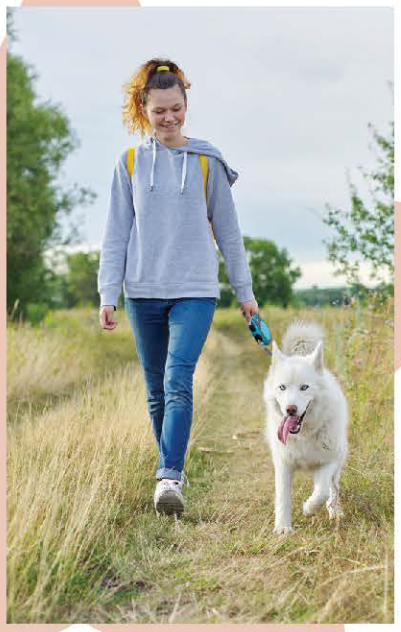
PREVENTIVE SCREENINGS AND SERVICES

As part of the AzMT Wellness Program, preventive screenings and services are brought onsite to provide members a convenient and timely way to protect their health. Preventive screenings and services include the following:

- **Health Risk Assessment**: Provides a snapshot of risk factors to development of chronic conditions, such as cardiovascular disease and diabetes.
  - Biometrics include height, weight, BMI, blood pressure, and waist circumference.
  - Venipuncture blood draw includes Total Cholesterol, HDL, LDL, Triglycerides, Glucose, Kidney and Liver Function, Calcium, Electrolytes, PSA, and more!

- **Skin Cancer Screenings**: Comprehensive, full body skin screening provided onsite or in a mobile unit to detect a range of skin abnormalities.

- **Cardiac and Organ Screenings**: Unique screening brought onsite that provides the following tests:
  - Cardiac screening: includes ultrasounds looking for blockages, reduced blood flow and rupture of the Carotid Artery, Peripheral Arteries, and Abdominal Aorta.
  - Organ screening: includes ultrasounds looking for any abnormality including nodules, cysts or changes in the organs' structure through ultrasounds of the kidneys, liver, gallbladder, and thyroid.
  - Hearing Test.



- **Mammograms**: Routine mammography screenings are offered onsite in a mobile unit for women aged 40 and older annually. A one-time baseline screening mammogram is recommended for women aged 35-39.

- **Flu vaccinations**: Quadrivalent flu vaccinations is offered onsite to minimize risk of flu-related illness to create a more productive environment throughout flu season.

Preventive screenings and services brought onsite through the L.I.V.E. Wellness Program are covered at 100% for employees and dependents covered on the AzMT Medical Benefit Plan.

For questions, please reach out to your Human Resources Department.

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local Human Resources department.

Benefit	Vendor	Phone	Website or Email
Medical Plans – Third Party Administrator	AmeriBen	855-350-8699	www.myameriben.com
Medical Provider Network	BCBSAZ	877-475-8454	www.azblue.com/CHSnetwork
Prescription	Navitus	866-333.2757	www.navitus.com
Medical Review	AmeriBen	855-788-9053 Fax 833-730-7961	www.myameriben.com
Employee Assistance Program	SupportLinc	888-881-5462	www.supportlinc.com
Dental	Delta Dental	800-352-6132	www.deltadentalaz.com
Vision	VSP	800-877-7195	www.vsp.com
Life Insurance	Minnesota Life/Securian	800-392-7295	www.ochsinc.com
Telemedicine	Teladoc	800-835-2362	www.teladoc.com
Health Savings/Flexible Savings Account	Health Equity	866-346-5800 HSA 855-428-0447 FSA	www.healthequity.com
Plan Administrator	Gallagher Benefit Services	928-391-2297	Jaime_Schulenberg@ajg.com

City of Apache Junction - Contact	Phone	Email
Human Resources	480.474.2617	webmailhr@apachejunctionaz.gov

Legal Notices & Disclosures

PATIENT PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

WOMEN'S HEALTH & CANCER RIGHTS ACT

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 states 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.
- These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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 for their health premiums.

If you or your dependents are already enrolled in Medicaid (AHCCS) or CHIP, and you think you or any of your dependents might be eligible for either of these programs you can contact:

ARIZONA – CHIP
https://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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Arizona Metropolitan Trust (AzMT) is committed to the privacy of your health information. The administrators of the Arizona Metropolitan Trust (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You are provided a copy of this Notice when you enroll in a health plan and receive your Summary Plan Document. You may also receive a copy of the Notice of Privacy Practices by contacting Jaime Schulenberg at 928.391.2297 or at Jaime_Schulenberg@ajg.com.

HIPAA Special Enrollment Rights

Arizona Metropolitan Trust Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Arizona Metropolitan Trust .To participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction.

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within insert "30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Jaime Schulenberg, Pool Administrator at 928.391.2297 or Jaime_Schulenberg@ajg.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete a form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from AzMT
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. 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 your 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 offer 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 by all of its medical 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.

When Can You Join a Medicare Drug Plan?

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.

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 not 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.

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 nineteen 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.

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

Contact Jaime Schulenberg, listed on page 34, 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1 800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:	**Arizona Metropolitan Trust**
Contact—Position/Office:	**Jaime Schulenberg, Pool Administrator**
Office Address:	**c/o Gallagher Benefit Services** **333 E. Osborn Rd., Ste.270** **Phoenix, AZ 85012**
Phone Number:	**928.391.2297**

WELLNESS PROGRAM DISCLOSURE: ALTERNATIVE STANDARD

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, AzMT L.I.V.E. will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are Gallagher Benefit Services and in some cases, a health coach, or a registered nurse or doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Jaime Schulenberg, AzMT's Pool Administrator, at Jaime_Schulenberg@ajg.com or 928.391.2297.

NOTICE REGARDING WELLNESS PROGRAM

AzMT L.I.V.E. is a voluntary wellness program available to all employees covered under the Arizona Metropolitan Trust Medical Plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a Fasting Blood Glucose and Complete Lipid Profile blood test, as well as voluntary blood tests for thyroid (TSH, T3.T4 and T7), PSA and A1C. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of Virgin Pulse Points which can be used for purchases in the Virgin Pulse Store. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive Virgin Pulse Points.

Additional incentives of Virgin Pulse points and/or nominal-value incentive prizes such as cups, lunch boxes, etc. may be available for employees who participate in certain health-related activities, Virgin Pulse challenges, Flu immunizations, Skin Cancer screenings, lunch and learns, etc. If you are unable to participate in any of the health-related activities, required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Laura Montini, at Wellbeing Consultant at 928.391.2311.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as diabetes or weight management. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, AzMT L.I.V.E. will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.
Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information Gallagher Benefit Services and in come cases, a health coach, or a registered nurse or doctor in order to provide you with services under the wellness program.

In addition, all medical information are obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Jaime Schulenberg, AzMT's Pool Administrator, at Jaime_Schulenberg@ajg.com or 928.391.2297.

COBRA GENERAL NOTICE

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your Human Resources Department.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Name of Entity:	Arizona Metropolitan Trust (AzMT)
Contact Person:	Jaime L. Schulenberg, Pool Administrator
Address:	c/o Gallagher Benefit Services 333 E. Osborn Rd., Ste. 270 Phoenix, AZ 85012
Phone Number:	(928) 391-2297

[1] When does Medicare coverage start? | Medicare

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your dependents must promptly furnish the City of Litchfield Park 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 City timely notice of the above noted events may:

- Cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage;
- Cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability;
- Cause claims to not be able to be considered for payment until eligibility issues have been resolved; or
- 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.

Disclaimer

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 Human Resources Department.

This document is an outline of the coverage provided under your employer's benefit plans. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources Department.

Arizona Metropolitan Trust
July 1, 2024 – June 30, 2025

This benefit guide was prepared by

Gallagher

Insurance | Risk Management | Consulting