

# Employee Benefit Guide



**December 1, 2024 – June 30, 2025**

## TIPS AND IMPORTANT INFORMATION

- Select the plans that are right for you. Review the Medical/Rx plan comparison charts (pages 5-11), dental and vision benefits (page 13-16), and life insurance information (pages 17-19)
- Enroll or make changes using the Enrollment/Change Form Available in your packet or from Finance
- Don't delay – enroll or make your changes on or before 5:00 p.m. November 19
- Submit any additional required documentation to Finance by 5:00 p.m. November 19
- Detailed benefit plan information and more can be found in this Guide or from Finance.
- Contact Patrick Larrabee via email at [plarrabee@guadalupeaz.org](mailto:plarrabee@guadalupeaz.org) or call 480.730.3080, if you have benefit questions.



Annual  
Enrollment is  
November 11  
through  
November 19,  
2024

## TABLE OF CONTENTS

About your Benefits	4
Medical and Prescription Coverage	5-10
Flexible Spending Accounts (FSA)	11
Dental Coverage	12
Vision Coverage	13-14
Life and Accidental Death & Dismemberment Insurance	15-17
Additional Benefits	18
Wellness Information	19-20
Contact Information	21
Legal Notices	22-40



This Benefit 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 more information about your Town of Guadalupe benefits, please call or email Patrick Larrabee at 480.730.3080 or [plarrabee@guadalupez.org](mailto:plarrabee@guadalupez.org).

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

***The benefits and premium costs contained in this Benefits Guide are effective December 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 34 for more details.**

## About Your Benefits

At the Town of Guadalupe 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 Patrick Larrabee at 480.730.3080 or plarrabee@guadalupeaz.org.

## Eligibility and Enrollment

You are eligible to participate in the Town of Guadalupe 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;
- Domestic Partners; and/or
- Unmarried children of any age who are mentally or physically disabled.

Your benefits begin on the first day of the month following your date of hire.

## 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, and FSA.

## 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 qualified life 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
- 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 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, effectiveness and which are covered by AzMT.
- **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](http://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.

**EPO:** This Plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible (\$175/\$350) so you will pay copays until you reach your annual out-of-pocket maximum (\$1,600/\$3,200). Under this Plan, there is coverage **ONLY** when you use an EPO provider, except in the case of a life-threatening emergency.

**PPO:** This Plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible (\$450/\$875 In-Network/\$1,200/\$2,400 Out-of-Network), so you will pay copays until you reach your annual out-of-pocket maximum (\$2,100/\$4,200 In-Network/\$3,000/\$6,000 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 (\$150/\$300 In-Network/\$300/\$600 Out-of-Network), so you will pay copays until you reach your annual out-of-pocket maximum (\$1,750/\$3,500 In-Network/\$3,000/\$6,000 Out-of-Network).

The PPO and PPO Buy-Up 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.

Please note that Mayo is not covered under any of the AzMT plans except for transplants. Please also note that because this is a short-plan year, we have pro-rated the deductibles and out-of-pocket maximums.



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 Rates and the provider can balance bill you, potentially leaving you 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](http://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](http://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](http://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/Diphtheria, Hepatitis A, Hepatitis B, Meningitis, Shingles, MMR, HPV, Pertussis and Varicella. To see if your pharmacy is participating, contact Navitus Customer Care at 866.333.2757.

### **Dispense as Written Penalty**

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

### **CVS**

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

# Medical and Prescription Coverage

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Comprehensive healthcare also provides peace of mind.

EPO Plan		
	IN-NETWORK	NON-NETWORK
Deductible (Individual/Family)	\$175/\$350	Not Covered
Coinsurance	10%	Not Covered
Out-of-Pocket Maximum (Individual/Family)	\$1,600/\$3,200	Not Covered
Pharmacy Out-of-Pocket Maximum	\$2,400/\$4,800	
<b>BASIC &amp; PHYSICIAN CARE</b>		
Preventive Care	\$0	Not Covered
Primary Care Office Visit	\$20 co-payment/visit, deductible waived	Not Covered
Specialist Office Visit	\$40 co-payment/visit, deductible waived	Not Covered
Virtual Visits	Same as Office Visit	Not Covered
Diagnostic Lab*/X-Ray	10% co-insurance after deductible *No Charge when labs are received at a free-standing facility.	Not Covered
Imaging (MRI/CT/Pet Scans, Etc.)	10% co-insurance after deductible	Not Covered
<b>SICK AND QUICK CARE</b>		
Urgent Care Facility	\$50 co-pay/visit, deductible waived	Not Covered
Emergency Room	\$300 co-payment/visit, plus 20% co-insurance after deductible	
<b>HOSPITALIZATION</b>		
Inpatient Hospital	10% co-insurance after deductible	Not Covered
Outpatient Surgery	10% co-insurance after deductible	Not Covered
<b>PHARMACY</b>		
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 a maximum of \$300/30-day supply	

## Finding In-Network Providers

Log on to [www.azblue.com/CHSNetwork](http://www.azblue.com/CHSNetwork) or call the number on your Member ID Card to find providers in the BCBSAZ network.



## PPO Plan

	IN-NETWORK	NON-NETWORK
Deductible (Individual/Family)	\$450/\$900	\$1,200/\$2,400
Coinsurance	20%	50%
Out-of-Pocket Maximum (Individual/Family)	\$2,100/\$4,200	\$3,000/\$6,000
Pharmacy Out-of-Pocket Maximum	\$2,100/\$4,200	
<b>BASIC &amp; PHYSICIAN CARE</b>		
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
<b>SICK AND QUICK CARE</b>		
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	
<b>HOSPITALIZATION</b>		
Inpatient Hospital	20% co-insurance after deductible	50% co-insurance after deductible
Outpatient Surgery	20% co-insurance after deductible	50% co-insurance after deductible
<b>PHARMACY</b>		
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](http://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)	\$150/\$300	\$300/\$600
Coinsurance	20%	50%
Out-of-Pocket Maximum (Individual/Family)	\$1,750/\$3,500	\$3,000/\$6,000
Pharmacy Out-of-Pocket Maximum	\$2,100/\$4,200	
<b>BASIC &amp; PHYSICIAN CARE</b>		
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 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
<b>SICK AND QUICK CARE</b>		
Urgent Care Facility	\$50 co-pay/visit, deductible	50% co-insurance after deductible
Emergency Room	\$300 co-payment/visit, plus 20% co-insurance after deductible	
<b>HOSPITALIZATION</b>		
Inpatient Hospital	20% co-insurance after deductible	50% co-insurance after deductible
Outpatient Surgery	20% co-insurance after deductible	50% co-insurance after deductible
<b>PHARMACY</b>		
Generic	\$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](http://www.azblue.com/CHSNetwork) or call the number on your Member ID Cards to find providers in the BCBSAZ network.



## Employee Medical Costs.

EPO				
Coverage Tier	Total Premium	Town Monthly Contribution	Employee Monthly Contribution	Per Pay Period
Employee Only	\$729.54	\$729.54	\$0	\$0
Employee + Spouse	\$1,487.07	\$1,189.66	\$297.41	\$148.71
Employee + Child(ren)	\$1,366.00	\$1,092.80	\$273.20	\$136.60
Employee + Family	\$2,031.88	\$1,625.51	\$406.38	\$203.19

PPO Plan				
Coverage Tier	Total Premium	Town Monthly Contribution	Employee Monthly Contribution	Per Pay Period
Employee Only	\$695.26	\$695.26	\$0	\$0
Employee + Spouse	\$1,414.68	\$1,131.74	\$282.94	\$141.47
Employee + Child(ren)	\$1,300.45	\$1,040.36	\$260.09	\$130.05
Employee + Family	\$1,928.45	\$1,542.76	\$385.69	\$192.85

PPO Buy-Up Plan				
Coverage Tier	Total Premium	Town Monthly Contribution	Employee Monthly Contribution	Per Pay Period
Employee Only	\$711.44	\$711.44	\$0	\$0
Employee + Spouse	\$1,445.85	\$1,156.68	\$289.17	\$144.59
Employee + Child(ren)	\$1,331.37	\$1,065.10	\$266.27	\$133.14
Employee + Family	\$1,977.26	\$1,581.81	\$395.45	\$197.73

# 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 dependent care expenses for you and your family.

	Health Care FSA	Dependent 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	An account that allows you to set aside pre-tax dollars from each paycheck to pay for a eligible child or elder care expenses while you and your spouse work full time.
What expenses are eligible?	You can use the funds to pay for qualified expenses such as: copayments, coinsurance, prescriptions, dental expenses, vision expenses, etc.. <a href="http://www.irs.gov/publications/p502/index.html">www.irs.gov/publications/p502/index.html</a>	Daycare expenses for your tax-dependent children under age 13 or dependents who are mentally or physically incapable of caring for themselves (including elderly dependents).
When can I use the funds?	All of the funds you elect are available on the first day of the plan year	Funds are available as you contribute to your account with each paycheck
How do I pay for eligible expenses?	With your Health Equity debit card	You will pay for your expenses out-of-pocket and then seek reimbursement – instructions on reimbursements are located here: <a href="https://my.healthequity.com">https://my.healthequity.com</a> .
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.	You may contribute up to \$5,000 to your dependent care 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 this 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 [www.healthequity.com](http://www.healthequity.com) to access the online portal.



### “Use it or Lose it” Rule

The health care FSA and dependent care FSA run on a plan year basis. The current plan year is from December 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 ends. **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	Town Monthly Contribution	Employee Monthly Contribution	Per Pay Period
<b>Basic</b>				
Employee Only	\$43.41	\$43.41	\$0.00	\$0.00
Employee + Spouse	\$83.47	\$66.78	\$16.69	\$8.35
Employee + Child(ren)	\$93.41	\$74.73	\$18.68	\$9.34
Employee + Family	\$137.68	\$110.14	\$27.54	\$13.77
<b>Buy-Up</b>				
Employee Only	\$44.95	\$44.95	\$0	\$0
Employee + Spouse	\$86.57	\$69.26	\$17.31	\$8.66
Employee + Child(ren)	\$101.66	\$81.33	\$20.33	\$10.17
Employee + Family	\$149.98	\$119.98	\$30.00	\$15.00



### 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.deltadental.com](http://www.deltadental.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
<b>EYE EXAM</b> (Once every fiscal year)	\$10 co-pay	\$10 co-pay
<b>LENSES</b> (Once every fiscal year)		
Prescription Glasses	\$20 co-pay	\$10 co-pay
Lenses	Single Vision, 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 Custom Progressives \$25
<b>FRAMES</b> (Once every fiscal year)		
Frame Allowance	\$150 \$170 for Featured Frames (20% off Remaining Balance) \$150 Walmart/Sam's Club Frames \$80 Costco Frames	\$225 \$245 for Featured Frames (20% off Remaining Balance) \$225 Walmart/Sam's Club Frames \$120 Costco Frames
<b>CONTACT LENSES</b> (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 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](http://www.truhearing.com/vsp).

## Employee Vision Costs

Coverage Tier	Total Premium	Town Monthly Contribution	Employee Monthly Contribution
		Base	
Employee Only	\$7.62	\$7.62	\$0
Employee Spouse	\$16.87	\$13.50	\$3.37
Employee + Child(ren)	\$14.87	\$11.90	\$2.97
Employee + Family	\$24.00	\$19.20	\$4.80
		Buy Up	
Employee Only	\$10.97	\$10.97	\$0
Employee + Spouse	\$24.71	\$19.77	\$4.94
Employee + Child(ren)	\$22.89	\$18.31	\$4.58
Employee + Family	\$37.26	\$29.81	\$7.45

### Finding In-Network Eye Doctors

You can find an in-network eye doctor in the VSP network by visiting [www.vsp.com](http://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 Town		Supplemental Life Insurance
Employee	\$25,000 Full-Time Employees \$50,000 Fire (Age Reduction = 65% at Age 65)	Increments of \$10,000 up to a total of \$750,000
Dependent Life	N/A	Spouse – Increments of \$5,000 up to \$250,000 (not to exceed employee’s total basic supplemental coverage)  Child(ren)– Increments of \$2,500 up to \$10,000 or \$15,000 (one premium insures all children from live birth to age 26)
AD&D	1x annual salary, up to \$300,000 maximum	Increments of \$10,000 up to \$500,000

**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 Finance.

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

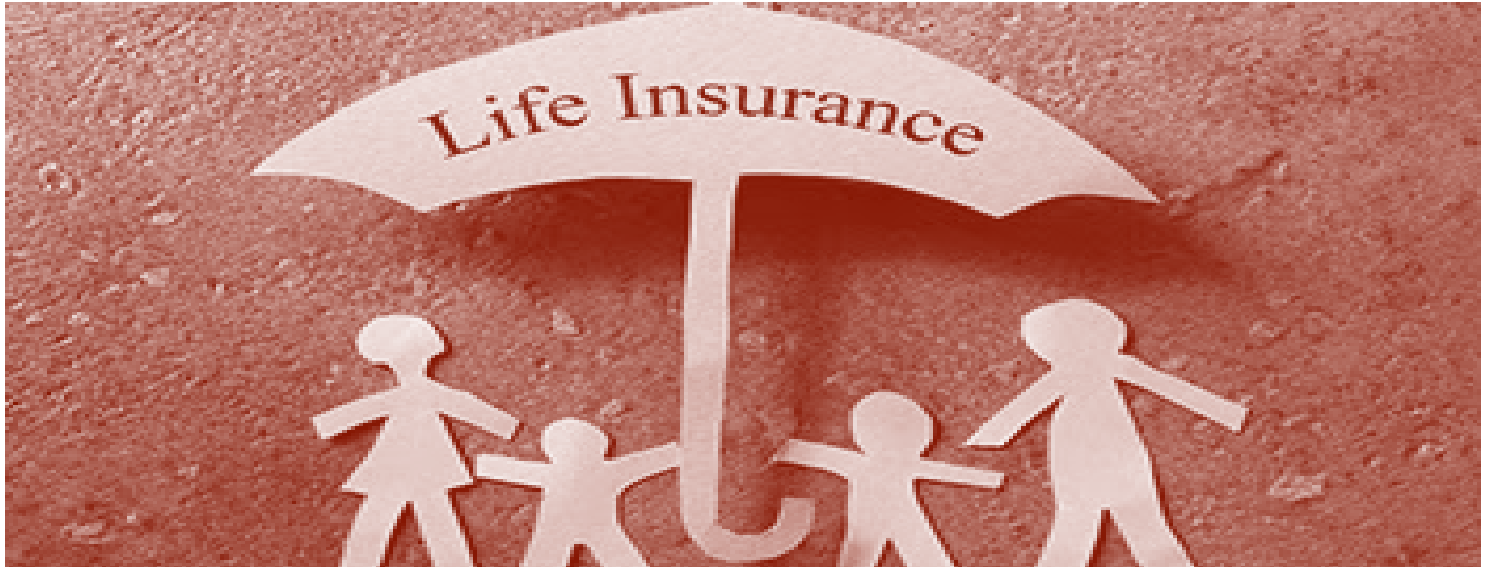
### Keep Your Beneficiaries Up to Date

- ❖ 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. Spouse can be covered in increments of \$5,000 up to \$250,000 but cannot exceed the employee's life insurance amounts. Child(ren) can be covered in increments of \$2,500 to \$10,000 or \$15,000, not to exceed 100% of employee's Basic and Supplemental amount.

Voluntary AD&D provides additional financial protection if 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 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 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](http://www.lifebenefits.com/insuranceneeds) to determine the right amount for you.



## Supplemental Life/AD&D

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:**

**$\$.080 \times 20 = \$1.60$  per month or  $\$.74$  per pay period**

\*Insurance amounts are rounded to the nearest thousandth.

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

**Example: Employee with three children interested in \$10K of supplemental dependent life insurance:**

**$\$.013 \times 10 = \$1.30$  per month or  $\$.60$  per pay period**

**All children receive a \$10,000 benefit.**

The cost of Voluntary AD&D coverage is available to employees who want to add additional coverage as outlined below:

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

**$\$.045 \times 100 = \$4.50$  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: EPO \$20, PPO and PPO Buy-Up \$25. For further details, visit [www.Teladoc.com](http://www.Teladoc.com).

## Employee Assistance Program

All benefit eligible employees are provided with an employer paid Employee Assistance Program (EAP) through Supportline. 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. Supportline 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; and
- 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.supportline.com](http://www.supportline.com)



## Get started!

[supportline.com](http://supportline.com)

Group code: **azmt**



Download the  
mobile app today!



# 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.

## Virgin Pulse 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](https://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/s1/U6vbW00/azmtnewsletter>



## AzMT L.I.V.E.

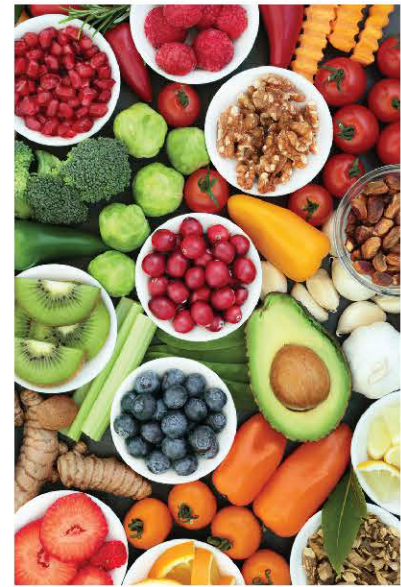
### PREVENTIVE SCREENINGS AND SERVICES

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 Human Resources Department.

Benefit	Vendor	Phone	Website or Email
Medical Plans – Third Party Administrator	AmeriBen	855-350-8699	<a href="http://www.myameriben.com">www.myameriben.com</a>
Medical Provider Network	BCBSAZ	877-475-8454	<a href="http://www.azblue.com/CHSnetwork">www.azblue.com/CHSnetwork</a>
Prescriptions	Navitus	866-333.2757	<a href="http://www.navitus.com">www.navitus.com</a>
Medical Review	AmeriBen	855-788-9053 Fax 833-730-7961	<a href="http://www.myameriben.com">www.myameriben.com</a>
Employee Assistance Program	SupportLinc	888-881-5462	<a href="http://www.supportlinc.com">www.supportlinc.com</a>
Dental	Delta Dental	800-352-6132	<a href="http://www.deltadentalaz.com">www.deltadentalaz.com</a>
Vision	VSP	800-877-7195	<a href="http://www.vsp.com">www.vsp.com</a>
Life Insurance	Minnesota Life/Securian	800-392-7295	<a href="http://www.ochsinc.com">www.ochsinc.com</a>
Telemedicine	Teladoc	800-835-2362	<a href="http://www.teladoc.com">www.teladoc.com</a>
Flexible Savings Account	Health Equity	866-382-3510 HSA 855-428-0447 FSA	<a href="http://www.healthequity.com">www.healthequity.com</a>
Plan Administrator	Gallagher Benefit Services	928-391-2297	<a href="mailto:Jaime_Schulenberg@ajg.com">Jaime_Schulenberg@ajg.com</a>

Town of Guadalupe - Contact	Phone	Email
Finance	480.730.3080	<a href="mailto:plarrabee@guadalupez.gov">plarrabee@guadalupez.gov</a>



# Legal Notices & Disclosures

	<b>Page</b>
Patient Protections Against Surprise Medical Bills	24-25
Women's Health & Cancer Rights Act	26
Newborn's and Mothers' Health Protection Act	26
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)	27
HIPAA Notice of Privacy Practices Reminder	28
HIPAA Special Enrollment Rights	29-30
Notice of Creditable Coverage	31-33
Wellness Program Disclosure: Alternative Standard	34
Notice Regarding Wellness Program	35
Protections from Disclosure of Medical Information	36
COBRA General Notice	37-41
Timely Notice for Status Changes	42

## **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 balance 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 believe you've been wrongly billed** you may contact the No Surprises Help Desk (NSHD) at [www.cms.gov/nosurprises](https://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](http://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.**

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**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](http://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](http://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](mailto: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](mailto: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 36, 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](http://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](http://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).**

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



## **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](mailto: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 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 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](mailto: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](http://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<sup>1</sup> 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](http://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](http://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

<sup>1</sup> <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>

## **YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE**

You or your dependents must promptly furnish the Town of Guadalupe 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 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,  
December 1, 2024 – June 30, 2025

This benefit guide prepared by



**Gallagher**

Insurance | Risk Management | Consulting




## WELCOME TO THE ARIZONA METROPOLITAN TRUST (AzMT)!!

We want to help make the transition to AzMT as seamless as possible, especially for those of you who may have chronic illnesses or are currently being assisted with managing illnesses or injuries.

If you are interested in talking with someone about your ongoing medical care needs, including benefit coverage, provider network status, etc., please call AmeriBen Customer Care at 855.350.8699.

We also want to make sure you are aware of any changes in how your current prescriptions are covered. Please call or email AzMT's Pool Administrator, Jaime Schulenberg, at 928.391.2297 or [Jaime\\_Schulenberg@ajg.com](mailto:Jaime_Schulenberg@ajg.com) to find out what tier your medication is on.



 <b>ARIZONA Metropolitan Trust</b>	<b>EMPLOYMENT STATUS</b>			<b>EFFECTIVE DATE OF COVERAGE/CHANGE</b>		
	<input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA					
<b>SOC. SEC. #</b>	<b>EMPLOYEE'S LAST NAME</b>			<b>FIRST NAME</b>		<b>MIDDLE INITIAL</b>
<b>MAILING ADDRESS</b>			<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	<b>HOME PHONE NUMBER</b>
						<b>EMAIL ADDRESS</b>
<b>MARITAL STATUS</b>		<b>GENDER</b>		<b>DATE OF BIRTH</b>		<b>DATE OF FULL TIME HIRE</b>
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DOMESTIC PARTNER		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		MONTH DAY YEAR		
						<b>HOURS WORKED PER WEEK (ACTIVE EMPLOYEES ONLY)</b>
<b>MEDICAL COVERAGE OPTIONS</b>						
<p>Select one health plan and one coverage level to enroll:</p> <p><input type="checkbox"/> EPO   <input type="checkbox"/> PPO   <input type="checkbox"/> PPO BUY-UP   <input type="checkbox"/> Waive Coverage*</p> <p><input type="checkbox"/> Employee   <input type="checkbox"/> Employee + Spouse   <input type="checkbox"/> Employee + Child(ren)   <input type="checkbox"/> Employee + Family</p>				<p>*Employees waiving coverage must complete the Waiver of Coverage located on Page 2 of this Benefit Enrollment/Change Form</p> <p><i>NOTE: Eligible children include natural, step, adopted, or children for which you have legal guardianship. Please refer to your current Summary Plan Document for full eligibility requirements.</i></p>		
<b>DENTAL COVERAGE OPTIONS</b>				<b>VISION COVERAGE OPTIONS</b>		
<p>Select one dental plan and one coverage level to enroll:</p> <p><input type="checkbox"/> Basic Dental (\$2,000 Annual Benefit)*   <input type="checkbox"/> Buy-Up Dental (\$4,000 Annual Benefit)**</p> <p><input type="checkbox"/> Employee   <input type="checkbox"/> Employee + Spouse   <input type="checkbox"/> Employee + Child(ren)   <input type="checkbox"/> Employee + Family   <input type="checkbox"/> Waive Coverage</p> <p><small>*Basic Dental Plan – Dependent children are eligible up to age 19 only.  **Buy-Up Dental Plan – Dependent children are eligible up to age 26.</small></p>				<p>Select one vision plan and one coverage level to enroll:</p> <p><input type="checkbox"/> Basic Vision*   <input type="checkbox"/> Buy-Up Vision**</p> <p><input type="checkbox"/> Employee   <input type="checkbox"/> Employee + Spouse   <input type="checkbox"/> Employee + Child(ren)   <input type="checkbox"/> Employee + Family   <input type="checkbox"/> Waive Coverage</p> <p><small>*Basic Vision Plan – Dependent children are eligible up to age 19 only.  **Buy-Up Vision Plan – Dependent children are eligible up to age 26.</small></p>		

**IMPORTANT: YOU MUST FULLY COMPLETE THE FOLLOWING IF SPOUSE/DOMESTIC PARTNER AND/OR DEPENDENT COVERAGE IS BEING REQUESTED**

ADD	DEL	NAME	DATE OF BIRTH	SOCIAL SECURITY # (REQUIRED)	RELATION	PLAN
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision



**OTHER INSURANCE INFORMATION**

Do you or your dependents currently have other: Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, give name of policyholder and insurance company.		
If anyone you are requesting coverage for is currently on Medicare please provide the following:	ID Number _____	Part A Effective Date ____/____/____	
	Part B Effective Date ____/____/____	Part D Effective Date ____/____/____	

**AUTHORIZATION AND SIGNATURE**

The group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits. I hereby apply for benefits to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the policyholder. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this benefit.

The information provided above is correct to the best of my knowledge. I certify under penalty of perjury that the dependents listed on this form fully meet the listed definition of eligibility. I will provide, if requested, documentation regarding my relationship (marriage or birth certificate, adoption certificate, divorce decree, etc.) to any dependent and his/her age. I will notify my employer within 31 days of a change in my listed dependents eligibility for employer-provided health benefits. I understand that if I do not enroll myself or my dependents, I must read and sign the waiver portion of this form.

\_\_\_\_\_  
**Signature of Employee**

\_\_\_\_\_  
**Date**

**WAIVER OF COVERAGE (COMPLETE AND SIGN THIS SECTION IF YOU ARE WAIVING COVERAGE)**

Medical/Rx benefits are being waived for (Name) \_\_\_\_\_ for the following reason(s): \_\_\_\_\_

- Group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits.
- I waive coverage for myself and/or my dependents and elect not to participate.
- I understand that I am waiving this coverage even though my employer may be providing the coverage at little or no cost to me.
- I understand that by waiving enrollment because of other health insurance coverage, I may in the future be able to enroll in this plan, provided that I request enrollment within 31 days after other coverage ends. In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself or my dependents provided that I request enrollment within 31 days of the status change.
- I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

\_\_\_\_\_  
**Signature of Employee**

\_\_\_\_\_  
**Date**

**TO BE COMPLETED BY HUMAN RESOURCES ONLY**

<input type="checkbox"/> New Employee/Rehire	Hire/Rehire Date ____/____/____	Effective Date ____/____/____
<input type="checkbox"/> Add/Delete Dependents	Effective Date of Change ____/____/____	Qualifying Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Loss of Dependent Status <input type="checkbox"/> Death <input type="checkbox"/> Other
<input type="checkbox"/> Termination of Insurance	Termination Date ____/____/____	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Name/Address Change	HR Dept. Initials _____ Date ____/____/____    Data Input: _____ (HR Initials)



# DECLARATION OF DOMESTIC PARTNERSHIP

## I. Declaration

We, \_\_\_\_\_ and \_\_\_\_\_, each  
(print or type employee name) (print or type name)  
certify and declare that we are domestic partners meeting all of the following requirements:

- a. We currently reside together in an exclusive mutual commitment similar to marriage and have done so for at least the last 12 consecutive months and each intend to continue the relationship indefinitely;
- b. We are not married to each other or any other individual (statutory or common law), and neither of us is a member of another domestic relationship;
- c. We are both at least 18 years of age;
- d. We are not related by blood or a degree of closeness which would prohibit marriage under the laws of the State of Arizona;
- e. Each of us is the other's sole domestic partner and is responsible for the other's common welfare;
- f. We are jointly responsible for basic living expenses;
- g. We were both mentally competent to consent to contract when the domestic partnership began and remain so for purposes of contracting for domestic partner health insurance coverage or the dependent life insurance benefit;
- h. We are financially interdependent, jointly responsible for the other's basic living expenses and are able to provide documents providing at least three of the following situations to demonstrate that such interdependence has existed for a minimum of the last 12 consecutive months:
  1. Joint mortgage, joint property tax identification or joint tenancy on a residential lease;
  2. Joint bank, investment or credit account;
  3. Joint liabilities (e.g., credit cards, car loans);
  4. Joint ownership of real property of a common leasehold, interest in real property, such as a residence or business, or common ownership of an automobile;
  5. A will which designates the other as the primary beneficiary or a beneficiary designation form currently in effect for a retirement plan or life insurance policy setting forth that one partner is the beneficiary of the other;
  6. Designation of one partner as holding power of attorney for health care or durable property for the other; and/or

7. Written agreement(s) or contract(s) regarding your relationship showing mutual support obligations.

## **II. Change in Domestic Partnership**

We understand and agree that we have an obligation to notify the Arizona Metropolitan Trust (AzMT), in writing, if any of the above criteria are no longer met. Examples of changes that could affect eligibility for coverage of one or more of the domestic partners and any eligible children include:

- a. Termination of the domestic partnership through death or dissolution;
- b. A change in one of the domestic partner's residence;
- c. A change in the financial interdependence as described above; or
- d. Loss of employment of the eligible employee.

## **III. Dependent Children of the Non-Eligible Employee Domestic Partner**

We understand and agree that the following dependent child(ren) (print name(s) of the child(ren) of domestic partner) \_\_\_\_\_ of \_\_\_\_\_ (print name of non-eligible employee domestic partner) are eligible for coverage if the child(ren) meet(s) the following criteria:

- a. Unmarried;
- b. Primarily dependent on the domestic partner for support (meaning over half of their support for the calendar year was received from the domestic partnership);
- c. Living with the domestic partners in a regular parent child relationship; and
- d. Is/are defined as an eligible child by the Internal Revenue Code Section 152.

## **IV. Acknowledgements**

- a. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in the Declaration or for failure to notify AzMT of changed circumstances as required above. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify AzMT of changed circumstances affecting eligibility for coverage for my domestic partner and their children may lead to disciplinary action against me, including discharge from employment
- b. We have provided the information in this Declaration for use by AzMT for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand that the information provided in this Declaration will be treated as confidential by AzMT but will be subject to disclosure: 1) upon the express written authorization of one or both of the undersigned; or 2) as required by law.

- c. We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.
- d. We understand and agree that AzMT will send Explanation of Benefits for medical services received to the employee for all covered members under the insurance contract and that such Explanation of Benefits may contain personal, private and confidential information.

We affirm under penalty of perjury, that the statements in this Declaration are true and correct.

**EMPLOYEE**

**DOMESTIC PARTNER**

\_\_\_\_\_  
(Last, First, MI)

\_\_\_\_\_  
(Last, First, MI)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security No.

\_\_\_\_\_  
Social Security No.

\_\_\_\_\_  
Common Residence Address (Street, City, State, Zip)

\_\_\_\_\_  
Mailing Address (Street, City, State, Zip)

State of Arizona                    )  
ss.                                        )  
County of \_\_\_\_\_)

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

by \_\_\_\_\_ and \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires:  
\_\_\_\_\_



## **DOMESTIC PARTNER TAX ACKNOWLEDGEMENT**

I, \_\_\_\_\_ (employee) acknowledge and understand that the medical benefits provided to my domestic partner and/or children or my domestic partner will be treated as taxable income to me unless my domestic partner and/or children of my domestic partner qualifies as a dependent under Section 152 of the Internal Revenue Code.

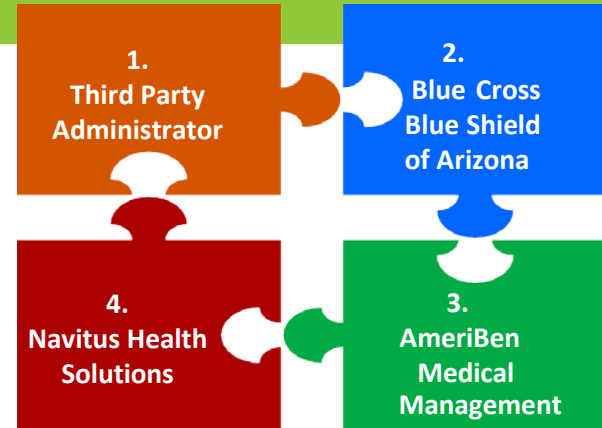
Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Domestic Partner Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## AzMT THE PIECES TO THE HEALTHCARE PUZZLE

# How the Healthcare Puzzle Works...



### **1. Third Party Administrator: AmeriBen**

Third Party Administrator (TPA) — After all of this you might be wondering where does AmeriBen fit into the picture? AmeriBen works with your plan to administer and process your health insurance claims. After you have received services from your participating network provider and they have pre-certified any necessary services, the claim is then sent by the provider to our office for processing and payment. There are many elements to a claim that can affect how the claim is processed.

### **2. Preferred Network: Blue Cross Blue Shield of Arizona**

PPO Providers — When you seek medical care the first thing you do is locate a provider such as a physician or hospital. Your benefit plan has entered into an agreement with a preferred network organization or preferred provider network. The network is a group of physicians & hospitals contracted with your benefit plan to accept discounted rates in order to help reduce the effect of rising healthcare costs. [www.azblue.com/CHSNetwork](http://www.azblue.com/CHSNetwork)

### **3. Medical Management: AmeriBen Medical Management**

Pre-certification Review — Certain health services including, hospital admissions, specific outpatient services, etc. may require pre-certification, prior to services being rendered. Please refer to your Plan Document for complete details. You may also hear this referred to as Medical Management. This program helps to determine if the requested services are appropriate for reimbursement. Medical Management does not guarantee benefits nor does it validate eligibility.

### **4. Pharmacy Benefit Manager: Navitus Health Solutions**

Pharmacy Benefit Manager (PBM) — At times you may need to take a medication prescribed by your physician. Your plan has an agreement with a PBM which contracts with pharmacies to provide reduced fees for covered medications. Contact information for your PBM can be found on your identification card.

#### Important Tips:

- Confirm your provider has a copy of your ID card.
- When you receive a bill from a provider it is important that you have an Explanation of Benefits (EOB) from AmeriBen that matches the date of service & charges. If you do not, call your provider to ensure they have billed AmeriBen.
- Review your EOB carefully and make sure you pay anything that is due to the provider directly to the provider. If you have any questions about how your claim was processed please call AmeriBen's Customer Care Center 1-855-350-8699



# MyAmeriBen.com and MyAmeriBen Mobile

Your resources for claims, benefits, and eligibility information





## Register your account today.

To register online:

1. Visit [www.MyAmeriBen.com](http://www.MyAmeriBen.com)
2. If you are a first-time user, select the **Click here to register** button.
3. Complete all fields on the registration page. Be sure to enter your full legal name. If you enter a nickname, your information will not match the information in the database, and you will not be able to register.
4. Create a secure password that is at least eight characters long and contains at least one special character (!@#\$\$&\*).
5. Choose **Submit** and accept the *Terms and Conditions* that will appear.

To register on MyAmeriBen Mobile:

1. Download MyAmeriBen Mobile on your iOS or Android device.  
2. Open the app.
3. If you have previously logged in to MyAmeriBen.com, use the same username and password for MyAmeriBen Mobile. If you have not previously created a user profile, select **Create an Account** on the homepage and follow the instructions.
4. Read and accept the licensing agreement.
5. Confirm your identity.



### Claims status

Check the status of your medical claims 24/7. View general summaries and detailed reports.



### Digital ID card

Never lose your card again. It's easy to download and send straight to providers.



### Online support

Chat with our online support specialists in real time or submit a question to be answered via email within two business days.



### Benefit information

Access general plan information including your plan document, benefit information, and provider networks.



### Document upload

Use your smartphone's camera to instantly upload claims documents.

If you need help registering or have questions, please call Customer Service at **855-350-8699**

# Shop for a doctor just like you shop for everything else.

Search for and **compare healthcare providers** in your Blue Cross® Blue Shield® of Arizona network.



[azblue.com/chsnetwork](https://azblue.com/chsnetwork)

## SEARCH FEATURES

**Results** are displayed in a list and on a map.

**Compare** providers to your needs.

**Advanced search** allows you to filter results based on quality certifications, specialties, and other categories.



Hello,  
What are you searching for today?



### Doctors by Name

See locations, network status and if the doctor accepts new patients.



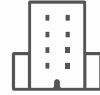
### Doctors by Specialty

Find in-network doctors who specialize in certain conditions.



### Places by Name

See address, hours, network status, and other important information.



### Places by Type

Search for in-network hospitals, labs, or urgent-care clinics near you.

## FIND A DOCTOR QUICKLY AND EASILY:

1. Visit [azblue.com/chsnetwork](https://azblue.com/chsnetwork).
2. Select “**Arizona PPO**” from the “Choose a Plan” drop-down menu.
3. Click the orange **Find a Doctor** button.
4. Define your **search area** by current location or enter a city or zip code.

Your network includes contracts with labs, durable medical equipment suppliers, and specialty pharmacies that are outside of Arizona. Those providers will not appear in search results unless you enter the state associated with these providers' addresses.

Blue Cross Blue Shield of Arizona provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield Plans outside Blue Cross Blue Shield of Arizona's service area.

Blue Cross, Blue Shield, and the Cross and Shield Symbols are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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## UPDATED PRE-CERTIFICATION LIST EFFECTIVE JULY 01, 2024

Arizona Metropolitan Trust has contracted with AmeriBen to provide medical management services. Those services include pre-certification and case management. Following is an updated pre-cert list will be effective 07/01/2024 as follows:

- Inpatient Admissions (surgical and non-surgical excluding routine newborn deliveries, long term acute care, skilled nursing/rehabilitation facility, inpatient substance abuse/mental disorder treatments including residential facilities)
- Inpatient and outpatient surgical procedures including pain management injections and intra-articular hyaluronic acid injections (excluding outpatient office surgical procedures and screening colonoscopies)
- 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 including (other than cornea), but not limited to, kidney, liver, heart, lung and 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 testing/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)
- 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*

## Experience Convenient Access to Your Pharmacy Benefits with the Navitus Member Portal

Have questions about your pharmacy benefits? Answers are just a click away!

Tools to help you make the most of your pharmacy benefits are at your fingertips, 24 hours a day, 7 days a week. Log in to Navitus' secure member portal at [www.navitus.com](http://www.navitus.com) or visit your plan's website for access to:



Cost Information



Medication History



Pharmacy Search



Drug Search



Drug Side Effect and Interaction Search

Plus, the portal has more resources to help you including formulary listings and a self-service section with commonly used forms. You can also find information about mail order and convenient 90-day refills options (if applicable).\*

### Get Started Today!

Visit the secure member portal at [www.navitus.com/members](http://www.navitus.com/members) or your plan's website, or call the number on the back of your pharmacy ID card for more information or assistance with registration.

\* The Navitus member portal is for active members only. Available features may vary by plan..



## Get Easy Access to Your Prescription Benefits with Navitus' Mobile App

Enjoy greater convenience at your fingertips!

With our mobile app you can:

- Compare medication prices to find the lowest cost option for you
- Locate the most convenient network pharmacies
- Save your preferred pharmacies for quick and easy access
- See medication and benefit information
- Access your member ID card
- View and manage your current medications



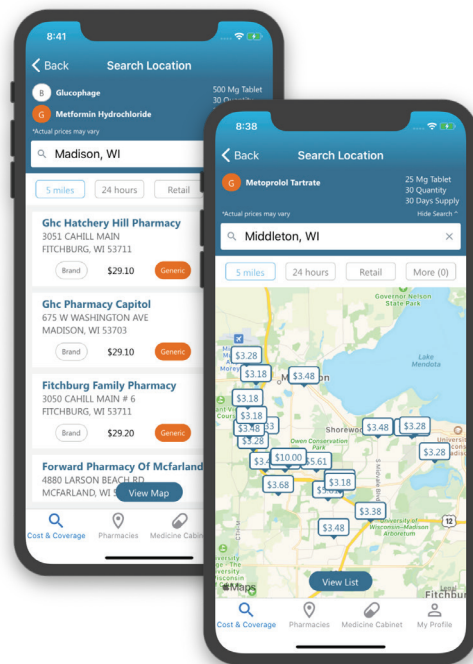
With just a few taps you can get help to make more informed prescription decisions and be on your way to better health. It's easy to use our mobile app. Just scan the QR code below to download now.

### For Mobile App Account Assistance Contact Customer Care:

Open 24 hours a day, 7 days a week

844-268-9789

Download the Navitus Prescription Benefits mobile app today!\*



Price data is for display purposes only

\* Registration is simple and secure and may require your member ID. The app is available to iOS and Android users. You must be 18 years old or older and currently covered under Navitus' pharmacy benefit plan. Hover your phone's camera over the code to download the app.

## Frequently Asked Questions

### What is the difference between Traditional Mail Order and the Online Ordering service?

Traditional Mail Order requires you to order all your prescriptions via mail or phone. You must complete the included patient profile form and submit it to Costco Mail Order Pharmacy. Traditional Mail Order also accepts personal checks and Electronic Funds Transfer as forms of payment.

Online Ordering service requires you to order all your new prescriptions online at [pharmacy.costco.com](http://pharmacy.costco.com). You should discard the included patient profile form and create an online account. Please remember that each individual receiving medications must have their own unique email address in order to create an online account. All communication between you and the pharmacy will be done via email.

### How do I get more patient profile forms if I choose to use the Traditional Mail Order service?

Contact Costco Mail Order Pharmacy at 1-800-607-6861.

### When do I need to place my order?

It is Costco's goal to have your order in your hands 14 days after Costco receives it at the processing facility. Please allow a few extra days when placing an order for the first time. Please remember to calculate the amount of time it may take for your prescription(s) request to leave your household and reach the facility. Once Costco receives your order, it will leave the facility within one to four days. Costco offers free standard shipping. Expedited shipping options are available for an additional fee. If you do not receive your order in 14 days, please contact Costco Mail Order Pharmacy at the toll-free number provided.

### How can I ensure my order will not be delayed?

Please ensure you are providing Costco with a valid shipping address and valid payment information. Please ensure your name, address and phone number are written legibly on all submitted documents including the original prescription(s). Your physician must provide complete directions for use. Costco cannot dispense an order without valid instructions; "use as directed" will not be accepted. Please ensure your prescription is written for the maximum days supplied allowed by your plan (usually 90 days) and contains additional refills.

### How do I pay for my order?

Costco requires payment with every prescription order. The shipment of your prescription order may be delayed if: Costco does not receive payment in full at the time of order, if you have an unpaid balance with Costco Mail Order Pharmacy, or if your forms are not filled out completely. For your convenience and for quick and secure payments, Costco accepts Visa®, MasterCard and Discover credit cards. If you utilize Costco's Traditional Mail Order service, you may also make a payment by mailing a personal check with your order or supplying a voided check for Electronic Funds Transfer. Please refer to your benefits plan for co-pay information. Typically, orders paid with a credit card are processed up to two days faster.

### How will I know the cost of my prescription order?

It is your responsibility to know the co-pay(s) for your prescription order. For additional information, please contact your benefits provider.

### Where is my order being shipped from?

The Costco Mail Order Pharmacy is located in Corona, Ca. Costco will ship anywhere in the United States. Please be aware that shipping times may vary depending on where you are located in the country.

### When I receive my order, what will be included in the package?

Each package will include your prescription medication, prescription label and a drug monograph. All prescription bottles will be sealed with child-safety caps to prevent them from opening during shipment. If you select easy-open caps, they will be included in the package for you to switch once your package has safely arrived.



### Costco Mail Order Pharmacy Contact Information

**Costco Mail Order Pharmacy**  
215 Deininger Circle  
Corona, CA 92878-4711

**Costco Mail Order Pharmacy Customer Service**  
**1-800-607-6861 phone**  
**1-888-545-4615 fax**

Monday through Friday 5 a.m. to 7 p.m. (PST)  
Saturday 9:30 a.m. to 2 p.m. (PST)

Visit us online at:  
[pharmacy.costco.com](http://pharmacy.costco.com)



From our pharmacy to you  
**Mail Order Prescriptions**

CORONA



## Costco Mail Order Pharmacy Ordering Instructions

The Costco Mail Order Pharmacy is an extension of your current prescription drug benefit. Mail Order service allows you to take advantage of the convenience of having your maintenance medications delivered to your home or workplace.

Costco Mail Order Pharmacy offers two great ordering services: Traditional Mail Order and Online Ordering.



### 1. Traditional Mail Order

Costco Mail Order Pharmacy offers you a Traditional Mail Order service. To use this service, you will submit all new orders and refills by mail or phone. Please read the following details on how to utilize our Traditional Mail Order

service. If you would like to place your orders online using a computer, please skip the following section and follow the instructions under the Online Ordering portion of this document.

#### How do I begin using the Traditional Mail Order service?

Complete the included Traditional Mail Order Patient Profile form and submit it to the Mail Order Pharmacy.

#### How do I order a new prescription using the Traditional Mail Order service?

If you need to start your medication immediately or do not have enough to last you at least two weeks, request two prescriptions from your prescriber: One for an initial short-term supply of your maintenance medication that your local retail pharmacy can fill

immediately, and a second for a 90-day supply, including refills that can be submitted to Costco Mail Order Pharmacy.

- Send both your new 90-day supply prescription and your completed Mail Order Patient Profile form to the Costco Mail Order Pharmacy using the provided postage-paid envelope. If you do not have a written prescription, please obtain one from your prescriber.
- Costco Mail Order Pharmacy does not hold prescriptions. Please send only prescriptions to be ordered immediately. Once an order has been processed, it cannot be stopped. Costco cannot accept returns.

#### How do I order a refill using the Traditional Mail Order service?

- **Mail:** Each prescription order you receive will contain a Refill Order Form. Complete the form and return it to Costco Mail Order Pharmacy.
- or
- **Phone:** Call 1-800-607-6861. Costco's 24-hour automated telephone system guides you through the refill-ordering process. Be sure to have your prescription number available.

#### What form of payment may I use for Traditional Mail Order service?

For your convenience and to make quick and secure payments, Costco accepts Visa®, MasterCard and Discover credit cards. Costco Mail Order Service also accepts personal checks and Electronic Funds Transfer with a voided check. You must refer to your benefits plan for co-pay information. Typically, orders paid with a credit card are processed up to two days faster.



### 2. Online Ordering

Costco Mail Order Pharmacy also provides an Online Ordering service. If you choose to utilize Online Ordering, it is helpful that you are familiar with basic online purchasing processes, and that you have frequent access to your email account.

Most communication

between you and Costco Mail Order Pharmacy will be through email. When using this service, all orders for new prescriptions must be initiated online at [pharmacy.costco.com](http://pharmacy.costco.com). If you would prefer not to use our Online Ordering service, please refer to the Traditional Mail Order section of this document.

#### How do I set up an account online?

Visit [pharmacy.costco.com](http://pharmacy.costco.com). Click Sign In/Register. Select Create Account, and enter your email address and a password. Please note: Each patient (self, spouse, dependent(s), etc.), independent of whether or not they are covered by the plan, must have his or her own unique email address to create an online account. Enter all required information to set up your online patient account including information regarding drug allergies, medical conditions, brand/generic preferences, etc.

#### How do I order a new prescription using the Online Ordering service?

If you need to start your medication immediately or do not have enough to last you at least two weeks, request two prescriptions from your prescriber: One for an initial short-term supply of your maintenance

medication that your local retail pharmacy can fill immediately, and a second for a 90-day supply, including refills that can be submitted to Costco Mail Order Pharmacy.

- Visit [pharmacy.costco.com](http://pharmacy.costco.com). Click the "New Prescriptions" link and follow the steps below:
  1. Log in.
  2. Provide prescription information, including physician name, drug name and shipping method.
  3. Confirm your order and mail the prescription to the address provided.
- Costco Pharmacy will begin processing your order once this request and the original prescription is received at our facility.
- Costco Mail Order Pharmacy does not hold prescriptions. Please send only prescriptions to be ordered immediately. Once an order has been processed, it cannot be stopped. We cannot accept returns.

#### How do I order a refill using the Online Ordering service?

- **Phone:** Call 1-800-607-6861. Costco's 24-hour automated telephone system guides you through the refill ordering process. Be sure to have your prescription number available.
- or
- **Online:** Visit [pharmacy.costco.com](http://pharmacy.costco.com). Click the "Refill Prescriptions" link.

#### What form of payment may I use for the Online Ordering service?

For your convenience and to make quick and secure payments, Costco accepts Visa®, MasterCard and Discover credit cards.

# Flexible Spending Account

A healthcare FSA lets you use tax-free money to pay for eligible medical expenses.<sup>1</sup> FSAs help members realize significant savings on healthcare costs. Don't think of it as money deducted from your paycheck – think of it as money added to your wallet.

- Access annual contribution amount on day one
- Fast, hassle-free payments and reimbursement
- Pay for your spouse and dependents too



## Annual tax saving potential<sup>2</sup>

# \$640

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IRS Contribution Limit<sup>3</sup>

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**\$3,200**

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## Common eligible medical expenses:

- Pain relievers
- Doctor visits
- Dental cleaning
- Sleep aids
- Eyeglasses/contacts
- Cold/cough medicine
- Chiropractic care
- Insulin testing supplies



**See how much you can save**

[HealthEquity.com/  
Learn/FSA](https://HealthEquity.com/Learn/FSA)

<sup>1</sup>FSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize FSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | <sup>2</sup>The example is for illustrative purposes only. Estimated savings are based on a maximum annual contribution and an assumed combined federal and state income tax bracket of 20%. Actual savings will depend on your contribution amount and taxable income and tax status. | <sup>3</sup>Contribution limit is accurate as of 11/09/23. Each fall the IRS updates the FSA contribution limits. For the latest information, please visit: [HealthEquity.com/Learn](https://HealthEquity.com/Learn) | HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

**Flexible spending account (FSA)  
employee enrollment form**



Please return this form to your HR department.

<b>Employer information</b>	
Employer name	

<b>Account holder information</b>			
First name	M.I.	Last name	
SSN	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)	
Email address		Home phone	
Physical street address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

<b>FSA coverage</b>	
Coverage effective date	

<b>Annual elections</b>			
	Contribution per pay period	Number of pay periods remaining in plan year	Your annual election amount
<b>Flexible spending account</b>	\$	X	= \$
<b>Limited purpose flexible spending account (LPFSA)</b>	\$	X	= \$
<b>Dependent care flexible spending account (DCRA)</b>	\$	X	= \$
Contribution per pay period x number of pay periods = your annual election amount			

<b>Signature</b> <input type="checkbox"/> I decline to participate in the FSA plan.		
Print name	Signature	Date



**Delta Dental PPO plus Premier™  
Summary of Benefits  
For Group# 4720-10100110, 10100111, 10101110, 19100110  
Arizona Metropolitan Trust (AZMT)**

This Summary of Benefits should be read along with your Dental Benefits Booklet. Your Dental Benefits Booklet provides additional information about your Group Plan Sponsor's dental plan administered by Delta Dental, including information about plan exclusions and limitations. If a statement in this Summary of Benefits conflicts with a statement in the Dental Benefits Booklet, the statement in this Summary of Benefits applies to you and you should ignore the conflicting statement in the Dental Benefits Booklet. The percentages below are applied to your Group Plan Sponsor's dental plan allowance for each service and it may vary due to the dentist's network participation.\*

**Group Plan Sponsor** – Arizona Metropolitan Trust (AZMT)

**Dental Claims Administrator** – Delta Dental of Arizona

**Benefit Year** – July 1 through June 30

**Deductible** – \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, X-rays, sealants, periodontal maintenance, and orthodontic services.

**Benefit Maximum Payment** – \$2,000 per person total per Benefit Year on all services except orthodontic services. \$2,000 per person total per lifetime on orthodontic services.

**Child Age Limit** – To age 19

**Student Age Limit** – To age 19

**Covered Services** –

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
<b>Diagnostic &amp; Preventive</b>			
<b>Diagnostic and Preventive Services</b> – exams, cleanings, fluoride, and space maintainers	100%	100%	80%
<b>Sealants</b> – to prevent decay of permanent teeth	100%	100%	80%
<b>Radiographs</b> – X-rays	100%	100%	80%
<b>Periodontal Maintenance</b> – cleanings following periodontal therapy	100%	100%	80%
<b>Basic Services</b>			
<b>Emergency Palliative Treatment</b> – to temporarily relieve pain	80%	80%	60%
<b>Minor Restorative Services</b> – fillings	80%	80%	60%
<b>Endodontic Services</b> – root canals	80%	80%	60%
<b>Periodontic Services</b> – to treat gum disease	80%	80%	60%
<b>Oral Surgery Services</b> – extractions and dental surgery	80%	80%	60%
<b>Other Basic Services</b> – misc. services	80%	80%	60%
<b>Major Services</b>			
<b>Crown Repair</b> – to individual crowns	50%	50%	40%
<b>Major Restorative Services</b> – crowns	50%	50%	40%
<b>Relines and Repairs</b> – to bridges and dentures	50%	50%	40%
<b>Prosthodontic Services</b> – bridges, implants, and dentures	50%	50%	40%
<b>Orthodontic Services</b>			
<b>Orthodontic Services</b> – braces	50%	50%	50%
<b>Orthodontic Age Limit</b> –	from the age of 8 - No Age Limit	from the age of 8 - No Age Limit	from the age of 8 - No Age Limit

\* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

## Frequencies and Limitations

- Oral exams are payable twice per benefit year.
- Prophylaxes (cleanings) are payable three times per benefit year. Scaling (equivalent to one cleaning) is payable once in any two-year period. Full mouth debridement (equivalent to one cleaning) is payable once in any five-year period.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per benefit year for people age 17 and under.
- Sealants are payable once per tooth in any three-year period for bicuspids and first and second molars for people age 18 and under. The surface must be free from decay and restorations. Preventive resin restoration on molars is payable once per lifetime for people age 15 and under with moderate to high caries risk. Treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament is payable twice per tooth per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per benefit year. Full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Space maintainers and recement or rebond of space maintainers are payable once per area per lifetime for people age 13 and under. Distal shoe space maintainers are payable once per area per lifetime for people age eight and under.
- Endodontic treatment is payable once per tooth per lifetime. Endodontic retreatment is payable once per tooth in any three-year period.
- Root planing and scaling is payable once per quadrant in any two-year period. Only two quadrants of root planing and scaling can be performed on the same day.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are payable.
- Implants and prefabricated and custom fabricated abutments are payable once per tooth in any five-year period and subject to a \$1,000 maximum per tooth. Implant-related services are payable.
- Silver amalgam and composite resin (white) restorations are payable once per surface in any two-year period.
- Porcelain and resin facings on crowns are optional treatment.
- Crowns and onlays and associated procedures (cores, substructures) are payable once per tooth in any five-year period.
- Oral surgery, including simple and surgical extractions, is payable.
- Fabrication of athletic mouthguard is payable once in any two-year period for people age 18 and under. Occlusal guards are not payable.

## Special Health Care Needs

Members diagnosed with "special health care needs" (as defined below) that significantly impair the Member's ability to obtain routine covered dental services, may be eligible for additional services, including:

- Additional visits, consultations and/or exams
- Up to four total dental cleanings per benefit year
- Treatment delivery modifications, which may include limited anesthesia, when necessary for dental staff to provide oral health care

"Special health care needs" are any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition requiring medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Special health care needs may include:

- Intellectual and neurodevelopmental disabilities
- Environmental or congenital injuries leading to disability
- Chromosomal abnormalities
- Syndromes or sequences with craniofacial or airway abnormalities
- Other sequences that require special dental care needs
- Any other syndrome, sequence, or abnormality which is not otherwise specified but has a significant deleterious effect in activities of daily living and/or requires significant modification at home and/or in care settings

Special health care needs does not include anxiety, depression, or a fear of dentists or dental treatment (odontophobia).

In evaluating whether you qualify for this special health care needs benefit, your dentist will determine whether they need to change or add new equipment, increase procedure time, and/or change or require additional therapeutic regimes and/or techniques in order to treat you. In making the assessment, your dentist may ask you for documentation evidencing your special health care need. Your dentist will submit the required paperwork to us, and we will determine if you qualify for this benefit. There is no age limit on the special health care need benefit.

**Payment for Orthodontic Service** – When orthodontic treatment begins, your Dentist will submit a treatment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon treatment plan, Delta Dental will make an initial payment to you or your Participating Dentist upon insertion of the appliances or initial banding, equal to 50% of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services as set forth in this Summary of Benefits. Provided Member has current eligibility on the date of service 12 months from the date the appliances or initial banding were placed, Delta Dental will make an additional payment equal to the balance of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services. Maximum Payment for Orthodontic Services equals the lesser of Delta Dental's total Copayment for Orthodontic Services, the Maximum Payment per person total per lifetime on orthodontic services or the fee charged by your provider for orthodontic services.

**Eligible People** – As defined by the Employer Group. The Subscriber pays the full cost of this plan.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should a Subscriber or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Subscriber is enrolled (except under COBRA) and must be enrolled in the same plan as the Subscriber. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

**Dual Spouse** – If you and your Spouse are both eligible to enroll in this Dental Plan as Subscribers, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Subscribers under this Dental Plan.

Coverage ends at the end of the month that the Subscriber and/or Dependent is no longer eligible.



## Delta Dental PPO plus Premier™ Summary of Benefits For Group# 4720 Buy Up Plan Arizona Metropolitan Trust (AZMT)

This Summary of Benefits should be read along with your Dental Benefits Booklet. Your Dental Benefits Booklet provides additional information about your Group Plan Sponsor's dental plan administered by Delta Dental, including information about plan exclusions and limitations. If a statement in this Summary of Benefits conflicts with a statement in the Dental Benefits Booklet, the statement in this Summary of Benefits applies to you and you should ignore the conflicting statement in the Dental Benefits Booklet. The percentages below are applied to your Group Plan Sponsor's dental plan allowance for each service and it may vary due to the dentist's network participation.\*

**Group Plan Sponsor** – Arizona Metropolitan Trust (AZMT)

**Dental Claims Administrator** – Delta Dental of Arizona

**Benefit Year** – July 1 through June 30

**Deductible** – \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, X-rays, sealants, periodontal maintenance, and orthodontic services.

**Benefit Maximum Payment** – \$4,000 per person total per Benefit Year on all services except orthodontic services. \$2,000 per person total per lifetime on orthodontic services.

**Child Age Limit** – To age 26

**Student Age Limit** – To age 26

**Covered Services** –

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
<b>Diagnostic &amp; Preventive</b>			
<b>Diagnostic and Preventive Services</b> – exams, cleanings, fluoride, and space maintainers	100%	100%	80%
<b>Sealants</b> – to prevent decay of permanent teeth	100%	100%	80%
<b>Radiographs</b> – X-rays	100%	100%	80%
<b>Periodontal Maintenance</b> – cleanings following periodontal therapy	100%	100%	80%
<b>Basic Services</b>			
<b>Emergency Palliative Treatment</b> – to temporarily relieve pain	80%	80%	60%
<b>Minor Restorative Services</b> – fillings	80%	80%	60%
<b>Endodontic Services</b> – root canals	80%	80%	60%
<b>Periodontic Services</b> – to treat gum disease	80%	80%	60%
<b>Oral Surgery Services</b> – extractions and dental surgery	80%	80%	60%
<b>Other Basic Services</b> – misc. services	80%	80%	60%
<b>Major Services</b>			
<b>Crown Repair</b> – to individual crowns	50%	50%	40%
<b>Major Restorative Services</b> – crowns	50%	50%	40%
<b>Relines and Repairs</b> – to bridges and dentures	50%	50%	40%
<b>Prosthodontic Services</b> – bridges, implants, and dentures	50%	50%	40%
<b>Orthodontic Services</b>			
<b>Orthodontic Services</b> – braces	50%	50%	50%
<b>Orthodontic Age Limit</b> –	from the age of 8 - No Age Limit	from the age of 8 - No Age Limit	from the age of 8 - No Age Limit

\* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

## Frequencies and Limitations

- Oral exams are payable twice per benefit year.
- Prophylaxes (cleanings) are payable three times per benefit year. Scaling (equivalent to one cleaning) is payable once in any two-year period. Full mouth debridement (equivalent to one cleaning) is payable once in any five-year period.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per benefit year for people age 17 and under.
- Sealants are payable once per tooth in any three-year period for bicuspids and first and second molars for people age 18 and under. The surface must be free from decay and restorations. Preventive resin restoration on molars is payable once per lifetime for people age 15 and under with moderate to high caries risk. Treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament is payable twice per tooth per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per benefit year. Full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Space maintainers and recement or rebond of space maintainers are payable once per area per lifetime for people age 13 and under. Distal shoe space maintainers are payable once per area per lifetime for people age eight and under.
- Endodontic treatment is payable once per tooth per lifetime. Endodontic retreatment is payable once per tooth in any three-year period.
- Root planing and scaling is payable once per quadrant in any two-year period. Only two quadrants of root planing and scaling can be performed on the same day.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are payable.
- Implants and prefabricated and custom fabricated abutments are payable once per tooth in any five-year period and subject to a \$1,000 maximum per tooth. Implant-related services are payable.
- Silver amalgam and composite resin (white) restorations are payable once per surface in any two-year period.
- Porcelain and resin facings on crowns are optional treatment.
- Crowns and onlays and associated procedures (cores, substructures) are payable once per tooth in any five-year period.
- Oral surgery, including simple and surgical extractions, is payable.
- Fabrication of athletic mouthguard is payable once in any two-year period for people age 18 and under. Occlusal guards are not payable.

## Special Health Care Needs

Members diagnosed with "special health care needs" (as defined below) that significantly impair the Member's ability to obtain routine covered dental services, may be eligible for additional services, including:

- Additional visits, consultations and/or exams
- Up to four total dental cleanings per benefit year
- Treatment delivery modifications, which may include limited anesthesia, when necessary for dental staff to provide oral health care

"Special health care needs" are any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition requiring medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Special health care needs may include:

- Intellectual and neurodevelopmental disabilities
- Environmental or congenital injuries leading to disability
- Chromosomal abnormalities
- Syndromes or sequences with craniofacial or airway abnormalities
- Other sequences that require special dental care needs
- Any other syndrome, sequence, or abnormality which is not otherwise specified but has a significant deleterious effect in activities of daily living and/or requires significant modification at home and/or in care settings

Special health care needs does not include anxiety, depression, or a fear of dentists or dental treatment (odontophobia).

In evaluating whether you qualify for this special health care needs benefit, your dentist will determine whether they need to change or add new equipment, increase procedure time, and/or change or require additional therapeutic regimes and/or techniques in order to treat you. In making the assessment, your dentist may ask you for documentation evidencing your special health care need. Your dentist will submit the required paperwork to us, and we will determine if you qualify for this benefit. There is no age limit on the special health care need benefit.

**Payment for Orthodontic Service** – When orthodontic treatment begins, your Dentist will submit a treatment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon treatment plan, Delta Dental will make an initial payment to you or your Participating Dentist upon insertion of the appliances or initial banding, equal to 50% of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services as set forth in this Summary of Benefits. Provided Member has current eligibility on the date of service 12 months from the date the appliances or initial banding were placed, Delta Dental will make an additional payment equal to the balance of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services. Maximum Payment for Orthodontic Services equals the lesser of Delta Dental's total Copayment for Orthodontic Services, the Maximum Payment per person total per lifetime on orthodontic services or the fee charged by your provider for orthodontic services.

**Eligible People** – As defined by the Employer Group. The Subscriber pays the full cost of this plan.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should a Subscriber or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Subscriber is enrolled (except under COBRA) and must be enrolled in the same plan as the Subscriber. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

**Dual Spouse** – If you and your Spouse are both eligible to enroll in this Dental Plan as Subscribers, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Subscribers under this Dental Plan.

Coverage ends at the end of the month that the Subscriber and/or Dependent is no longer eligible.



# Special Health Care Needs Benefit

For the over 7 million people in the U.S. with intellectual or developmental disabilities, visiting the dentist for oral health care can be overwhelming or even inaccessible.<sup>1</sup> Delta Dental of Arizona is changing that by giving children and adults with special health care needs access to increased benefits.<sup>2</sup>

## What is included in this benefit?

If you or a covered family member are diagnosed with special health care needs that significantly impair your ability to get routine covered dental services, you may be eligible for additional services, including:

- Additional visits, consultations and/or exams
- Up to four total dental cleanings per benefit year
- Treatment delivery modifications, which may include limited anesthesia, when necessary for dental staff to provide oral health care

## What kind of special health care needs does this benefit cover?

People with any physical, developmental, mental, sensory, behavioral, cognitive or emotional impairment or a limiting condition requiring medical management, health care intervention, and/or the use of specialized services or programs may be eligible for additional services. This includes:

- Intellectual and neurodevelopmental disabilities
- Environmental or congenital injuries leading to disability
- Chromosomal abnormalities
- Syndromes or sequences with craniofacial or airway abnormalities
- Other sequences that require special dental care needs
- Any other syndrome, sequence, or abnormality that limits the ability to perform daily self-care or creates substantial limitations in a major life activity

## How do I use this benefit?

Let your dentist know that you or a family member have a qualifying special health care need and that your dental plan includes the special health care needs benefit. To help your dentist better understand the benefit and how to bill Delta Dental of Arizona for services provided, we suggest you take the attached "Special Health Care Needs Benefit - Dentist Instructions" flyer to your next dental visit.<sup>3</sup>

You can also scan the QR code to download the flyer:



 **DELTA DENTAL**®

deltadentalaz.com

<sup>1</sup>University of Minnesota Residential Information Systems Project. "People with IDD in the United States". Retrieved from: <https://risp.umn.edu>

<sup>2</sup>The special health care needs benefit is a standard benefit on most group and individual dental plans administered by Delta Dental of Arizona. Exceptions may apply, so check with your benefits administrator or your plan documentation to confirm this benefit is included in your dental plan.

<sup>3</sup>The special health care needs benefit provides coverage for qualifying members who receive eligible services April 1, 2024 and later.

# SPECIAL HEALTH CARE NEEDS BENEFIT

## Dentist Instructions

For the over 7 million people in the U.S. with intellectual or developmental disabilities, visiting the dentist for oral health care can be overwhelming or even inaccessible.<sup>1</sup> Together, we can change that.



You are receiving this information because you may have a patient with a qualifying special health care need. Delta Dental of Arizona provides additional dental benefits to help care for these individuals. Information about this benefit and how to submit claims is outlined below.

### What is included in this benefit?

1. **Exams:** Additional dental visits are covered, if needed to help patients understand what to expect prior to treatment. Procedure codes: D0120, D0145, D0150, D0160 and D0180.
2. **Cleanings:** Up to four dental cleanings in a benefit year. Procedure codes: D1110, D1120, D4346, D4355 and D4910.
3. **Treatment delivery modifications** necessary for dental staff to provide oral health care for patients with sensory sensitivities, behavioral challenges or other barriers to treatment. Procedure code: D9997.
4. **The use of anesthesia** when necessary to provide dental care. Procedure codes: D9222, D9223, D9230, D9239, D9243.

### Benefit Verification

Before rendering services, check the member's eligibility in the Dental Office Toolkit at [deltadentalaz.com/dentist](http://deltadentalaz.com/dentist). If the member's plan includes this benefit, it will typically be noted in the Exclusions and Limitations section of the member details and benefits. *Note: There is no age limit for the special health care needs benefit.*

### Submitting Claims

Once the benefit is verified, include procedure code D9997 (Dental Case Management – patient with special health care needs) on the claim, along with any other services that were rendered.

### FREE Continuing Education Series for Dental Staff



Penn Dental Medicine created a free continuing education series aimed at building awareness of—and to help provide access to—oral health care for individuals with disabilities. Scan the QR code or visit [www.dental.upenn.edu/disabilitiescare](http://www.dental.upenn.edu/disabilitiescare) to learn more.



<sup>1</sup>University of Minnesota Residential Information Systems Project, "People with IDD in the United States". Retrieved from: <https://risp.umn.edu>  
<sup>2</sup>The special health care needs benefit is a standard benefit on most group and individual dental plans administered by Delta Dental of Arizona. Exceptions may apply, so check with your benefits administrator or your plan documentation to confirm this benefit is included in your dental plan.

# A Look at Your VSP Vision Coverage

With VSP and Arizona Metropolitan Trust,  
your health comes first.




**Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.**


### Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over \$3,000 in savings.

### Provider choices you want.

 With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

### Shop online and connect your benefits.

 Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

### Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

### Using your benefit is easy!

Create an account on [vsp.com](https://www.vsp.com) to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

  
vision care

More Ways  
to Save

Extra

\$20

to spend on

**Featured Frame Brands†**

bebe

Calvin Klein

COLE HAAN

DRAGON

FLEXON

LONGCHAMP  
PARIS



and more

See all brands and offers  
at [vsp.com/offers](https://www.vsp.com/offers).

+

Up to

40%

Savings on

**lens enhancements‡**

Enroll through your employer today.  
Contact us: **800.877.7195** or [vsp.com](https://www.vsp.com)



# Your VSP Vision Benefits Summary

Arizona Metropolitan Trust and VSP provide you with a choice of affordable vision plans. Choose the eye care essentials, or upgrade to give your eyes extra love.

## PROVIDER NETWORK:

VSP Choice

## EFFECTIVE DATE:

07/01/2024



BENEFIT	DESCRIPTION	COPAY
<b>Standard Coverage with a VSP Provider</b>		
<b>WELLVISION EXAM</b>	<ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> <li>Routine retinal screening</li> <li>Every plan year*</li> </ul>	\$10 Up to \$39
<b>ESSENTIAL MEDICAL EYE CARE</b>	<ul style="list-style-type: none"> <li>Retinal imaging for members with diabetes covered-in-full</li> <li>Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.</li> <li>Coordination with your medical coverage may apply. Ask your VSP network doctor for details.</li> <li>Available as needed</li> </ul>	\$20 per exam
<b>PRESCRIPTION GLASSES \$20</b>		
<b>FRAME*</b>	<ul style="list-style-type: none"> <li>\$170 Featured Frame Brands allowance</li> <li>\$150 frame allowance</li> <li>20% savings on the amount over your allowance</li> <li>\$150 Walmart/Sam's Club frame allowance</li> <li>\$80 Costco frame allowance</li> <li>Every plan year</li> </ul>	Included in Prescription Glasses
<b>LENSES</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Impact-resistant lenses for dependent children</li> <li>Every plan year</li> </ul>	Included in Prescription Glasses
<b>LENS ENHANCEMENTS</b>	<ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 30% on other lens enhancements</li> <li>Every plan year</li> </ul>	\$0 \$95 - \$105 \$150 - \$175
<b>CONTACTS (INSTEAD OF GLASSES)</b>	<ul style="list-style-type: none"> <li>\$150 allowance for contacts; copay does not apply</li> <li>Contact lens exam (fitting and evaluation)</li> <li>Every plan year</li> </ul>	Up to \$60

BENEFIT	DESCRIPTION	COPAY
<b>Premium Coverage with a VSP Provider</b>		
<b>WELLVISION EXAM</b>	<ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> <li>Routine retinal screening</li> <li>Every plan year*</li> </ul>	\$10 Up to \$39
<b>ESSENTIAL MEDICAL EYE CARE</b>	<ul style="list-style-type: none"> <li>Retinal imaging for members with diabetes covered-in-full</li> <li>Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.</li> <li>Coordination with your medical coverage may apply. Ask your VSP network doctor for details.</li> <li>Available as needed</li> </ul>	\$20 per exam
<b>PRESCRIPTION GLASSES \$10</b>		
<b>FRAME*</b>	<ul style="list-style-type: none"> <li>\$245 Featured Frame Brands allowance</li> <li>\$225 frame allowance</li> <li>20% savings on the amount over your allowance</li> <li>\$225 Walmart/Sam's Club frame allowance</li> <li>\$120 Costco frame allowance</li> <li>Every plan year</li> </ul>	Included in Prescription Glasses
<b>LENSES</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Every plan year</li> </ul>	Included in Prescription Glasses
<b>LENS ENHANCEMENTS</b>	<ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Impact-resistant lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 30% on other lens enhancements</li> <li>Every plan year</li> </ul>	\$0 \$0 \$25 \$25
<b>CONTACTS (INSTEAD OF GLASSES)</b>	<ul style="list-style-type: none"> <li>\$175 allowance for contacts; copay does not apply</li> <li>Contact lens exam (fitting and evaluation)</li> <li>Every plan year</li> </ul>	Up to \$60

<b>ADDITIONAL SAVINGS</b>	<b>Glasses and Sunglasses</b>	<ul style="list-style-type: none"> <li>Discover all current eyewear offers and savings at <a href="https://vsp.com/offers">vsp.com/offers</a>.</li> <li>20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.</li> </ul>
	<b>Laser Vision Correction</b>	<ul style="list-style-type: none"> <li>Average of 15% off the regular price; discounts available at contracted facilities.</li> </ul>
	<b>Exclusive Member Extras for VSP Members</b>	<ul style="list-style-type: none"> <li>Contact lens rebates, lens satisfaction guarantees, and more offers at <a href="https://vsp.com/offers">vsp.com/offers</a>.</li> <li>Save up to 60% on digital hearing aids with TruHearing®. Visit <a href="https://vsp.com/offers/special-offers/hearing-aids">vsp.com/offers/special-offers/hearing-aids</a> for details.</li> <li>Enjoy everyday savings on health, wellness, and more with VSP Simple Values.</li> </ul>

## YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to [vsp.com](https://vsp.com) to find an in-network provider.

\*Plan year begins in July

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.

‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on [vsp.com](https://vsp.com).

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VSP, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare and VSP Premier Edge are trademarks of Vision Service Plan. Flexon and Dragon are registered trademarks of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners. 102898 VCCM



# Group Term Life Insurance Enrollment



Minnesota Life Insurance Company - a Securian Financial company  
Administered by Ochs, Inc. • 18-3789 • 400 Robert Street North, St. Paul, MN 55101-2025  
1-800-392-7295 • Fax 651-665-3791

**EMPLOYER NAME:**

**POLICY NUMBER:**

## EMPLOYEE INFORMATION

Name (first, middle initial, last)		Date of birth	
Address (street, city, state, zip)		Email address	
Date of employment	Annual salary	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
If request is due to a family status change, indicate date of change			

## SPOUSE INFORMATION (only complete if electing coverage)

Name (first, middle initial, last)	Date of birth	Social Security number
Address (street, city, state, zip; check here if same as above <input type="checkbox"/> )		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Email address		

## CHILDREN INFORMATION (only complete if electing coverage)

Name (first, middle initial, last)	Date of birth
------------------------------------	---------------

## AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for this insurance coverage. I've read the fraud warnings on the reverse side.

Employee signature <b>X</b>	Phone number	Date signed
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## **Fraud Warnings:**

**AR, LA, RI, WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**DC:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny benefits if false information materially related to a claim was provided by the applicant.

**FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KY:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime.

**ME:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NM:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OH:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OK:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**PA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**VA:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

**WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

# Group Life Insurance Evidence of Insurability



**Minnesota Life Insurance Company** - a Securian Financial company  
 Administered by Ochs, Inc. • 18-3789 • 400 Robert Street North, St. Paul, MN 55101-2025  
 1-800-392-7295 • Fax 651-665-3791

**EMPLOYER NAME:**

**POLICY NUMBER:**

## EMPLOYEE INFORMATION

Name (first, middle initial, last)	Date of birth	Phone number
------------------------------------	---------------	--------------

Address (street, city, state, zip)

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Annual salary	Date of employment
-------------------------------------------------------------------------	---------------	--------------------

Total amount of insurance requested \$	Email address
-------------------------------------------	---------------

## SPOUSE INFORMATION (only complete if coverage requires evidence of insurability)

Name (first, middle initial, last)	Date of birth	Phone number
------------------------------------	---------------	--------------

Address (street, city, state, zip; check here if same as above )

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Email address
-------------------------------------------------------------------------	---------------

Total amount of insurance requested \$
-------------------------------------------

## CHILDREN INFORMATION (only complete if coverage requires evidence of insurability)

Name	Date of birth	Name	Date of birth	Total amount of insurance requested \$

## HEALTH QUESTIONS (always complete for coverage that requires evidence of insurability)

Employee height	Employee weight	Spouse height	Spouse weight	Spouse occupation
-----------------	-----------------	---------------	---------------	-------------------

Employee Yes No	Spouse Yes No	Children Yes No	
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	1. In the last 7 years have you been diagnosed or treated for any of the following: <ul style="list-style-type: none"> <li>• Heart disease or disorder, chest pain</li> <li>• High blood pressure</li> <li>• Cancer or tumor</li> <li>• COPD, sleep apnea or other lung or respiratory disease</li> <li>• Stroke, TIA, seizure, epilepsy, or multiple sclerosis</li> <li>• Kidney or pancreas disorder</li> <li>• Ulcerative Colitis, Crohn's disease, bariatric surgery, or any stomach or intestinal disorder</li> <li>• Anemia, leukemia, or other blood disorder</li> <li>• Hepatitis B, Hepatitis C, or other liver disorder</li> <li>• Diabetes</li> <li>• Depression, bipolar disorder, or any mental disorder</li> <li>• Drug or alcohol misuse including addiction</li> <li>• Chronic pain, rheumatoid arthritis, psoriatic arthritis, lupus</li> <li>• AIDS, AIDS Related Complex, or HIV, including positive test results</li> <li>• ALS or muscular dystrophy</li> </ul>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	2. During the past 5 years, have you, for any reason other than the conditions in question 1, been hospitalized, had surgery, received medication, treatment or diagnostic testing (other than: acid reflux; allergies; birth control; high cholesterol; cold; appendix or gallbladder removal; underactive thyroid; kidney stones; pregnancy without complications; or minor infection)?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	3. Are any future inpatient or outpatient medical, surgical, or diagnostic procedures recommended or being considered by a medical professional (other than: routine lab testing or physical)?

Securian Financial is the marketing name for Minnesota Life Insurance Company. Insurance products are issued by Minnesota Life Insurance Company.

⇨⇨⇨⇨⇨ **Please provide details to all "Yes" answers on page 2 and sign page 3** ⇨⇨⇨⇨⇨



**EMPLOYER NAME:**

**POLICY NUMBER:**

**AUTHORIZATION**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, data aggregator, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Minnesota Life Insurance Company, (the Company), and its employees, reinsurers and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

I also authorize any person(s), medical practitioner, institution, insurance company or MIB, Inc. to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, Inc., to give such information to any agency employed by the Company to collect and transmit such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

This protected health information is to be disclosed under this Authorization so the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below. HIV-related information may not be released after 180 days from the date this Authorization is signed. Disclosure of HIV test results pertaining to my application for insurance is governed by A.R.S. 20-448.01. A copy of this Authorization is as valid as the original. I understand I or my authorized representative is entitled to receive a copy of this Authorization. I understand the information may be used for the purpose of performing actuarial or internal business studies, research, analytics and other analysis. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to the Company's legal right to contest the policy. In the case of an Authorization signed for the purpose of collecting information in connection with a claim for benefits under the policy, this Authorization shall be no longer than the term of coverage of the policy if the claim is for a health insurance benefit or the duration of the claim if the claim is not for a health insurance benefit. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I have read this Authorization and Consumer Privacy Notice and I understand I can have copies. The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I authorize my employer to withdraw premiums from my salary to pay for this coverage. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

Employee signature <b>X</b>	Date signed	Employee name (please print)	Date of birth
Spouse signature <b>X</b>	Date signed	Spouse name (please print)	Date of birth
Children (age 18 and older) signature <b>X</b>	Date signed	Children name (please print)	Date of birth

**FOR OFFICE USE ONLY:**

Employee		Spouse		Children		Dependent Life Package - Coverage Code 94	
Current in force	U/W applied for	Current in force	U/W applied for	Current in force	U/W applied for	U/W applied for spouse	U/W applied for child
\$	\$	\$	\$	\$	\$	\$	\$

# Group Accidental Death and Dismemberment Insurance Enrollment



**Minnesota Life Insurance Company** - a Securian Financial company  
Administered by Ochs, Inc. • 18-3789 • 400 Robert Street North, St. Paul, MN 55101-2025  
1-800-392-7295 • Fax 651-665-3791

**EMPLOYER NAME:**

**POLICY NUMBER:**

## EMPLOYEE INFORMATION

Name (first, middle initial, last)		Date of birth	Phone number
Address (street, city, state, zip)			
Email address			
Amount of insurance elected \$	Effective date:	Coverage for <input type="checkbox"/> Employee only <input type="checkbox"/> Employee and family	Date of employment

## AUTHORIZATION

I understand that Minnesota Life Insurance Company shall incur no liability until the first premium is paid, and that premiums for the contributory insurance will be deducted from my pay. I've read the fraud warnings on the reverse side.

Employee signature <b>X</b>	Employee name (please print)	Date signed
--------------------------------	------------------------------	-------------

## **Fraud Warnings:**

**AR, LA, RI, WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**DC:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny benefits if false information materially related to a claim was provided by the applicant.

**FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KY:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime.

**ME:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NM:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OH:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OK:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**PA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**VA:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

**WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.



## Beneficiary Designation



### Securian Life Insurance Company Minnesota Life Insurance Company

Administered by Ochs, Inc.

Group Customer Service • 400 Robert Street North, Suite 1880, St. Paul, MN 55101-2025

#### INSTRUCTIONS

1. Clearly print or type the information.
2. Sign and date the completed form.
3. Return to:

#### GENERAL BENEFICIARY INFORMATION

- Completing this Beneficiary Designation form will revoke all current beneficiary designations.
- The same person(s) cannot be named as both a primary and contingent beneficiary.
- If you need more space, attach an additional sheet of paper with all of the information required. Be sure to sign and date this additional information page.
- To receive a death benefit, a beneficiary must survive the insured. If the named beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category.
- When the signed and completed beneficiary form has been accepted, you will be mailed a confirmation.
- **Primary Beneficiary:** This is the individual(s), trust, charity, or estate that you want to receive the insurance benefit. You can divide the insurance proceeds between primary beneficiaries. The total shares must equal 100%.
- **Contingent Beneficiary:** If all the primary beneficiary(ies) are no longer living, eligible, or able to receive the benefits, it will be paid to the contingent beneficiary(ies) designated. You can divide the insurance proceeds between your named contingent beneficiaries. The total shares must equal 100%.
- **Naming Minor Children:** You may name your children (by name) directly, or to a trust. Minors cannot directly receive life insurance proceeds; however, they may be paid to a court-appointed guardian or held until the minor child is legal age.
- **Trust:** Provide the trust name, effective date and tax ID or Social Security number (if applicable) - i.e., "John Smith Trust dated 01/01/20xx."
- **Charity:** Provide the full name, address, tax ID number.

CONTINUE ON TO NEXT PAGE

Securian Financial is the marketing name for Securian Life Insurance Company and Minnesota Life Insurance Company. Insurance products are issued by Minnesota Life Insurance Company or Securian Life Insurance Company, a New York authorized insurer. Minnesota Life is not an authorized New York insurer and does not do insurance business in New York. Both companies are headquartered in Saint Paul, MN. Product availability and features may vary by state. Each insurer is solely responsible for the financial obligations under the policies or contracts it issues.

# Beneficiary Designation

Securian Life Insurance Company • Minnesota Life Insurance Company

Employer name		Policy number
Insured's name (first, middle initial, last)		ID (or last four of SSN)
Address (street, city, state, zip)		Email address
Insured's date of birth	Policyowner (if different than insured)	Policyowner's phone number

**This designation applies to selected coverage(s).** If this section is left blank, your designation will apply to all coverages. If your beneficiary(ies) are different by coverage, use a separate beneficiary form for each coverage.

All coverages

### PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit.

Beneficiary full name/trust name	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

**Total Primary Shares Must Equal 100%**

### CONTINGENT BENEFICIARY(IES) - Receives a benefit ONLY if all primary beneficiaries are no longer living.

Beneficiary full name/trust name	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

**Total Contingent Shares Must Equal 100%**

### SIGNATURE REQUIRED - This beneficiary form revokes all prior designations.

Insured or policyowner's penned signature	Date
-------------------------------------------	------

**X**

**Community Property State Consent for current and former residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin.** If you are married and live in, or previously lived in, a community property state and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit. You should consult with a qualified tax advisor and/or seek legal advice if you have any questions in connection with the Beneficiary Designation.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any right that I may have to the proceeds of such insurance under applicable community property laws. My spouse may withdraw this designation at any time but may not designate a different primary beneficiary without my consent.

Signature of spouse	Please print spouse name clearly	Date signed
---------------------	----------------------------------	-------------

**X**

# Getting started with Teladoc



Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.



**1**

**Online:**

Go to [Teladoc.com](http://Teladoc.com) and click "set up account".

**Mobile app:**

Download the app and click "Activate account". Visit [teladoc.com/mobile](http://teladoc.com/mobile) to download the app.

**Call Teladoc:**

Teladoc can help you register your account over the phone.

## SET UP YOUR ACCOUNT

Set up your account by phone, web or mobile app.



**2**

## PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.



**3**

## REQUEST A CONSULT

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

Talk to a doctor anytime for **\$45!**

 [Teladoc.com](http://Teladoc.com)

 1-800-Teladoc (835-2362)





# Healthy skin starts here

Get a diagnosis and treatment of your skin condition in just two business days or less

Welcome to the new way to get dermatology care that's easier than ever before. You no longer have to wait weeks for an appointment. Simply use your Teladoc account to upload images of your skin condition and one of our U.S. board-certified dermatologists will provide a diagnosis and treatment plan customized to fit your specific needs.

### Please note

- Our Dermatology service uses images only. Communication with the dermatologist takes place through the message center.
- Although call center reps cannot schedule dermatology appointments, they can answer questions at 1-800-835-2362.

### Here's how it works:

- 1 Request a consult**  
Log in to your Teladoc account online or through the mobile app anytime, anywhere.
- 2 Upload images**  
Take pictures of your skin condition and upload them to your account to share with the dermatologist.
- 3 View results online**  
Within 24 hours, you'll receive a response online from a licensed dermatologist. If necessary, a prescription will be sent to your pharmacy.

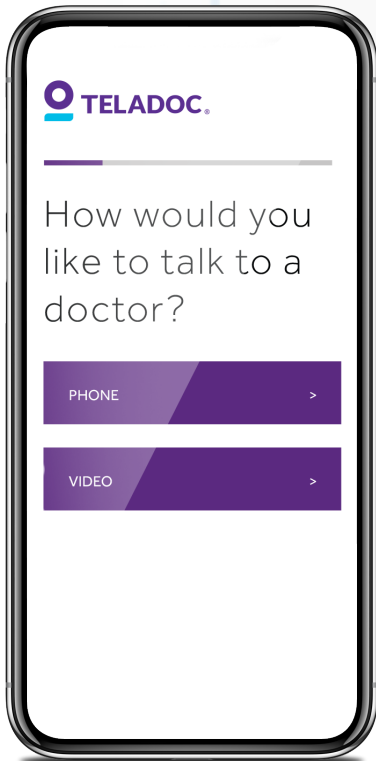
## Get healthier skin

Visit [Teladoc.com](https://www.teladoc.com)

Call 1-800-TELADOC (835-2362) | Download the app  

# Eat well. Live well. Stay well.

**Now available:** Nutrition visits by phone or video.



## You now have access to our new Nutrition service.

Talk to a registered dietitian for help with staying healthy, eating right, or managing a health condition like diabetes or high blood pressure.



Schedule your visit 7 days a week (7 a.m. to 9 p.m. local time)



Talk to a registered dietitian by phone or video



Get a personalized diet plan to meet your health needs

## Schedule your visit today

Visit [Teladoc.com/Nutrition](https://www.teladoc.com/Nutrition)

Call 1-800-TELADOC (835-2362) | Download the app  



# Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues



## In-the-moment support

Reach a licensed clinician by phone 24/7/365 when you call for assistance.



## Short-term counseling

Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.



## Coaching

Get assistance from a Coach to boost your emotional fitness, learn healthy habits, establish new routines, build your resilience and more.



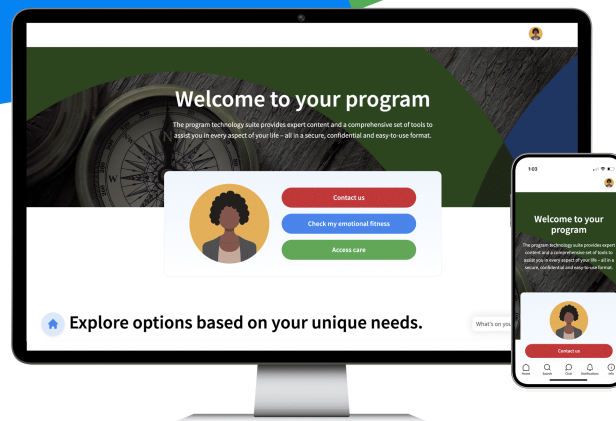
## Work-life benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.



## Confidentiality

Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.



## Your web portal and mobile app

- Create a personal profile to quickly access support from a licensed clinician
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos



## Start with Mental Health Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator assessment. You'll instantly receive personalized guidance to access care and support.



Download the mobile app today!



1-888-881-5462



supportlinc.com  
group code: azmt



# 2024-25 WELLNESS PROGRAM CALENDAR

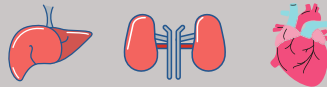
## July



Cardiac & Organ Screenings

## AUGUST

Cardiac & Organ Screenings



## SEPTEMBER

Flu Vaccinations



## OCTOBER

Mammography Screenings



Flu Vaccinations

## NOVEMBER

Mammography Screenings

Behavior Change Seminar



## DECEMBER



## JANUARY



## FEBRUARY

Health Risk Assessments



## MARCH

Health Risk Assessments



## APRIL

Skin Cancer Screenings



## MAY

Skin Cancer Screenings



## JUNE

Behavior Change Seminar

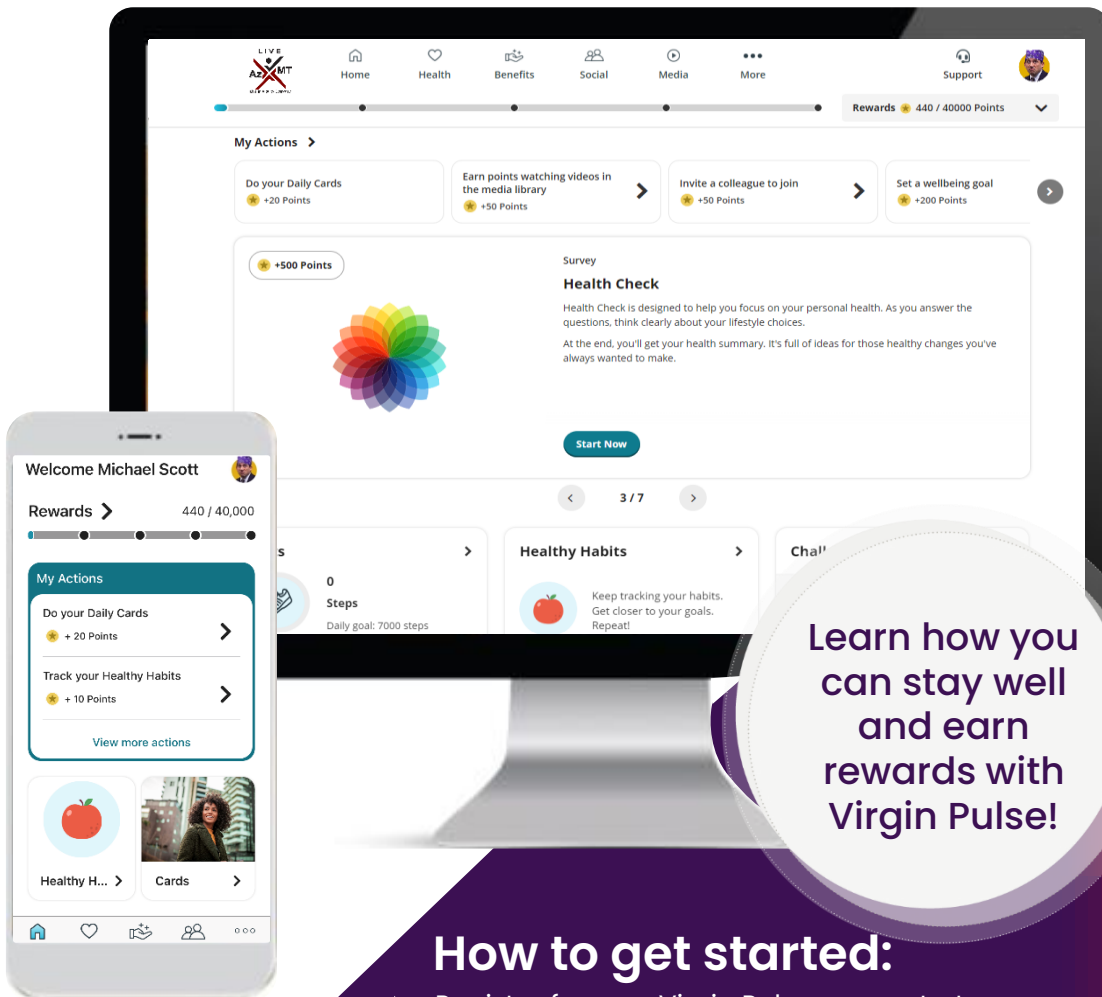


- Preventive screenings and services are subject to change. Watch for emails and flyers with more details.
- Preventive screenings and services brought onsite through the AzMT Wellness Program are covered 100% for eligible AzMT medical benefit plan members.
- For questions, contact [Kingman.GBS.ArizonaMetropolitanTrust@ajg.com](mailto:Kingman.GBS.ArizonaMetropolitanTrust@ajg.com).



# IT'S YOUR TIME TO THRIVE.

The Virgin Pulse wellbeing program gives you the tools to get active, get healthy, and get rewarded.



Learn how you can stay well and earn rewards with Virgin Pulse!

## How to get started:

- ➔ Register for your Virgin Pulse account at [join.virginpulse.com/azmt](https://join.virginpulse.com/azmt)
- ➔ **Download the Virgin Pulse mobile app** for iOS and Android. Plus, the first time you log in you'll earn bonus points!
- ➔ **Connect an activity tracker** to get credit for your steps, active minutes, and sleep. We sync with many devices and apps (Max Buzz, Fitbit, Apple Health, S Health, etc.)
- ➔ **Upload a profile picture and add friends.**
- ➔ **Set your interests** to get personalized daily tips to help you eat healthy, get active, reduce stress, sleep well, and more.

# Your Rewards

It's easy to earn points by making healthy decisions. You'll have the opportunity to earn up to \$100.00 this year by participating in the program, earning points, and achieving levels! Here is how your points will translate into rewards:



**Earn up to \$25 Pulse Cash per Quarter and up to \$100 per Program Year**

	Level 1	Level 2	Level 3	Level 4
<b>POINTS</b>	500	4,000	8,000	15,000
<b>REWARDS</b>	N/A	\$5 Pulse Cash	\$10 Pulse Cash	\$10 Pulse Cash

## How to Earn Points

\*go to your Reward page to see all of the ways to earn points\*

<b>Activity</b> Upload steps from your activity tracker (Max Buzz, Fitbit, Apple Health, S Health, Google Fit, etc.)	DAILY (up to 140 Points/day)	Per 1,000 steps 15 or more active minutes 30 or more active minutes 45 or more active minutes	10 Points 70 Points 100 Points 140 Points
	MONTHLY	20-Day Triple Tracker (moderate activity) 20-Day Triple Tracker (high activity)	400 Points 500 Points
<b>Nutrition &amp; Sleep</b>	DAILY	Calorie Tracking Track sleep manually Track sleep nightly via a device Sleep > 7 hours in a night	20 Points 10 Points 20 Points 50 Points
	DAILY	Track your healthy habits (up to 30 Points/Day)	10 Points
<b>Self Tracking</b>	MONTHLY	Track healthy habits 10 days in a month Track healthy habits 20 days in a month	200 Points 300 Points
	DAILY	Complete daily tip card (2/day)	20 Points
<b>Cards</b>	MONTHLY	Complete 10 daily cards in a month Complete 20 daily cards in a month	100 Points 200 Points
	MONTHLY	Create a personal challenge Join a personal challenge Join the Company Challenge	50 Points 100 Points 100 Points
<b>Challenges</b>	DAILY	Complete a step	15 Points
	QUARTERLY	Complete a Journey	250 Points
<b>Journeys</b>	ONE-TIME	Complete registration Add a profile picture Connect activity device First 5 friends First login to mobile app	100 Points 100 Points 200 Points 250 Points 250 Points
	YEARLY	Complete the Health Check Survey Complete the Tobacco Requirement Set a wellbeing goal	500 Points 250 Points 200 Points
<b>More!</b>	QUARTERLY	Set interests	100 Points



Sign up now at [join.virginpulse.com/azmt](https://join.virginpulse.com/azmt)  
 Already a member? Login at [member.virginpulse.com](https://member.virginpulse.com)  
 Questions? Contact Member Services at 888-671-9395





## **Stay Connected**

**Opt-in to AzMT Wellness program updates in order to receive:**

- **Reminders for upcoming on-site events**
- **Updates on new programs**
- **Important notices**

**Text**  
**AzMTWellness**  
**to**  
**833-942-4521**