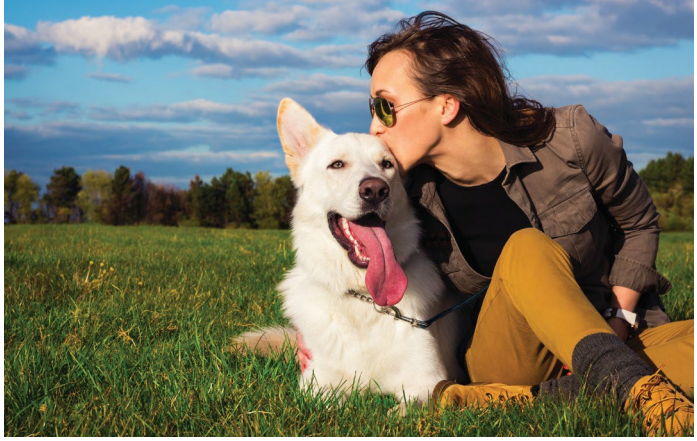
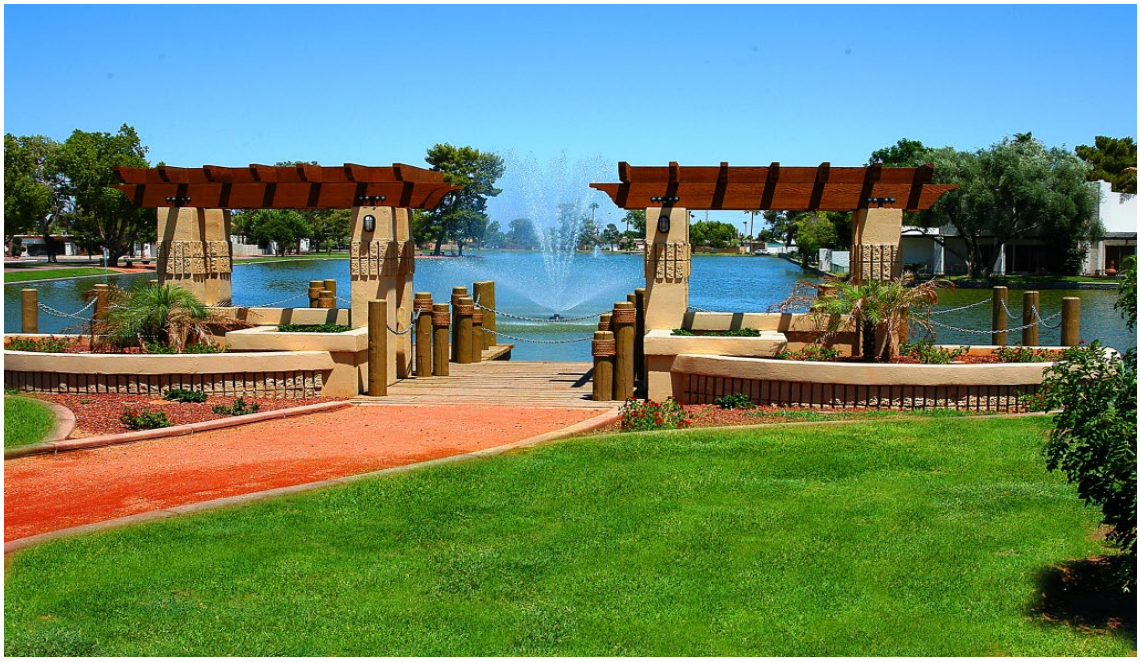


Employee Benefit Guide



AZ MT ARIZONA Metropolitan Trust

July 1, 2026 – June 30, 2027

BENEFITS OVERVIEW

At the Town of Fountain Hills, 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..

TABLE OF CONTENTS

Annual Enrollment Period:
April 16 – May 04, 2026

Enrollment changes must be completed and submitted by May 04, 2026. **Your current medical, dental, or vision elections will carry over if you do not make elections.**
Please note FSAs require annual enrollment.

BENEFITS OFFERED

- Medical
- Prescription
- Dental
- Vision
- Health Savings Account (HSA) & Flexible Spending Account (FSA)
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short Term Disability
- Long Term Disability
- Employee Assistance Program (EAP)
- Gallagher Marketplace
- Telemedicine
- Voluntary Benefits
- Leap Infusion Care
- Wellbeing Programs
- Maternal Health Program

ELIGIBILITY

You and your dependents are eligible for Fountain Hills benefits on the first of the month following 30 days of employment.

Eligible dependents are your spouse, children under age 26, or disabled dependents of any age that became disabled prior to age 26.

COBRA

COBRA continuation coverage can become available to an employee whose group health coverage through Fountain Hills has terminated. It can also become available to an employee's dependents who are covered under the group health plan when they lose their group health coverage. The employees and/or dependents must pay the full premium costs plus a 2% administration fee. For additional information about rights and obligations under the plan and under federal law, employees and dependents should review their Summary Plan Document or contact a Human Resources representative.

ENROLLMENT DATES AND DEADLINES

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 an election change.

	Enrollment Deadline	Effective Date of Coverage	Documentation Required
Currently Active	May 04, 2026	July 1, 2026	Social Security card, marriage and/or birth certificate or other court document for newly added spouse and/or dependents
New Hire or Rehire	Must enroll within 31 days of hire	First of the month following date of hire	Social Security card, marriage and/or birth certificate or other court document for newly added spouse and/or dependents
Making a Status Change (Part-time to Full-time)	Must enroll within 31 days of status change	First of the month following status change	Social Security card, marriage and/or birth certificate or other court document for newly added spouse and/or dependents
Qualifying Event	Must enroll within 31 days of qualifying event	Day of the life event	Social Security card, marriage and/or birth certificate or other court document for newly added spouse and/or dependents and proof of life event
Terminating Employment	Benefits automatically end	Last day of the month in which employee terminates	N/A

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 of eligible costs.
- **Out-of-pocket Maximum** – The maximum amount of copays, deductible and coinsurance you are responsible for in a plan year before the plan pays 100% of your eligible covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide healthcare services. In-network providers typically provide services at a lower negotiated rate. If you receive services from a provider that is **In-Network** it will cost you significantly less than going to a provider that is **Out-of-Network.**
- **Formulary Drug List:** A drug formulary is a list of generic and brand-name drugs that have been evaluated for safety and effectiveness, and that your insurance company considers “best choices.”
- **Generic Drugs**: FDA-approved and shown to be just as safe and effective as their more expensive brand-name counterparts.
- **Preferred Drugs:** Carriers regularly review the latest prescription drugs on the market and maintains a list of preferred drugs that are clinically effective and not cost-restrictive. These drugs are available at a lower price than those not included on the list, which are called non-preferred drugs.
- **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.

What's New for the 2026-27 Plan Year

For the 2026–27 plan year, Fountain Hills is introducing a few important benefit changes, a vendor change, and several new enhancements—effective July 1, 2026. These updates are designed to improve your experience, expand access, and better support your overall wellbeing.

BlueCard Program Added

- Members now have access to BlueCard, providing nationwide coverage through the Blue Cross Blue Shield network for out-of-state care. **THIS CHANGE WILL REQUIRE NEW ID CARDS FOR ALL MEMBERS!**

HDHP Changes

- The in-network deductible and out-of-pocket maximum have increased to $3,400 for individual coverage and $6,800 for family coverage.

Telehealth Changes

- Telehealth services will now be provided by Telehealth by AZ Blue. More information can be found on page 19.

Prescription Changes

- The Pharmacy Benefit Manager (PBM) is changing from Navitus to SmithRx. SmithRx is an innovative PBM that provides a fresh approach to managing pharmacy benefits. The plan includes access to a variety of savings programs to help you lower medication costs. **Please Note: This new program will require member engagement for some programs; failure to engage will result in denial of fills.** Members affected will be proactively contacted directly by SmithRx.

Life Insurance

- Securian is offering an open enrollment opportunity to add or increase Voluntary Life by up to $10,000 Guarantee Issue to current employees who have not elected $300,000 or more of coverage.

New Program: Leap Health

- Leap Health is an infusion care program that coordinates with patients to deliver care at home or at a local infusion clinic, making the experience more comfortable and less costly. Leap also provides alternative options for obtaining the specialty infusion medications at a lower cost. **Please Note: This new program will require member engagement.** More information is available on page 23.

New Program: Maternal Health

- AmeriBen's Maternal Health program connects you with essential resources, tools and answers to help ensure a healthy pregnancy and delivery for you and your baby.

MEDICAL BENEFITS

Administered by AmeriBen and BCBSAZ

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. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	HDHP	
	In-Network	Out-of-Network
Deductible (Individual / Family)	$3,400 / $6,800	$5,000 / $10,000
Out-of-Pocket Maximum (Individual / Family)	$3,400 / $6,800	$10,000 / $20,000
Coinsurance	0% after deductible	50% after deductible
DOCTOR'S OFFICE		
Preventive Care	$0	Not Covered
Primary Care Office Visit	0% after deductible	50% after deductible
Specialist Office Visit	0% after deductible	50% after deductible
Independent Lab/X-Ray (non-hospital owned)	0% after deductible	50% after deductible
Independent Diagnostic MRI / CT	0% after deductible	50% after deductible
Maternity Care	0% after deductible	50% after deductible
SICK AND QUICK CARE		
Telehealth by AZ Blue	Varies by Type of Service (See Page 19)	N/A
Urgent Care Facility	0% after deductible	50% after deductible
Emergency Room (True Emergency)	0% after deductible	0% after deductible
Inpatient Hospital	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible
MENTAL HEALTH		
Telehealth by AZ Blue	Varies by Type of Service (See Page 19)	N/A
Inpatient & Substance Abuse Services	0% after deductible	50% after deductible
Outpatient Services	0% after deductible	50% after deductible

BlueCross BlueShield of Arizona

Medical Network

It's important to verify providers are in your plan's network before you see them. Log in to www.azblue.com to find a provider in your network.

1. Click "Find Care" then "Browse the Network",
2. Type of Coverage is "Employer Provided", Type of Provider is "Medical" and Network is "Statewide/National PPO/EPO".
3. Choose your location and search

* Note Mayo Clinic is out-of-network except for transplants.

MEDICAL BENEFITS

Administered by AmeriBen and BCBSAZ

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. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	PPO	
	In-Network	Out-of-Network
Deductible (Individual / Family)	$750 / $1,500	$2,000 / $4,000
Out-of-Pocket Maximum (Individual / Family)	$3,500 / $7,000	$5,000 / $10,000
Coinsurance	20% after deductible	50% after deductible
DOCTOR'S OFFICE		
Preventive Care	$0	Not Covered
Primary Care Office Visit	$25 copayment/visit	50% after deductible
Specialist Office Visit	$45 copayment/visit	50% after deductible
Independent Lab/X-Ray (non-hospital owned)	20% after deductible	50% after deductible
Independent Diagnostic MRI / CT	20% after deductible	50% after deductible
Maternity Care	Initial visit: $25 copayment All other services: 20% after deductible	50% after deductible
SICK AND QUICK CARE		
Telehealth by AZ Blue	$25 copayment/visit	N/A
Urgent Care Facility	$50 copayment/visit	50% after deductible
Emergency Room (True Emergency)	$300 copayment, plus deductible and co-insurance ($300 copayment waived if admitted)	
Inpatient Hospital	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
MENTAL HEALTH		
Telehealth by AZ Blue	$25 copayment/visit	N/A
Inpatient & Substance Abuse Services	20% after deductible	50% after deductible
Outpatient Services	$25 copayment/visit	50% after deductible

BlueCross BlueShield of Arizona

Medical Network

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1. Click "Find Care" then "Browse the Network",
2. Type of Coverage is "Employer Provided", Type of Provider is "Medical" and Network is "Statewide/National PPO/EPO".
3. Choose your location and search

* Note Mayo Clinic AZ is out-of-network.

MEDICAL BENEFITS

Administered by AmeriBen and BCBSAZ

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. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	PPO BUY-UP	
	In-Network	Out-of-Network
Deductible (Individual / Family)	$250 / $500	$500 / $1,000
Out-of-Pocket Maximum (Individual / Family)	$3,000 / $6,000	$5,000 / $10,000
Coinsurance	20% after deductible	50% after deductible
DOCTOR'S OFFICE		
Preventive Care	$0	Not Covered
Primary Care Office Visit	$25 copayment/visit	50% after deductible
Specialist Office Visit	$45 copayment/visit	50% after deductible
Independent Lab/X-Ray (non-hospital owned)	20% after deductible	50% after deductible
Independent Diagnostic MRI / CT	20% after deductible	50% after deductible
Maternity Care	Initial visit: $25 copayment All other services: 20% after deductible	50% after deductible
SICK AND QUICK CARE		
Telehealth by AZ Blue	$25 copayment/visit	N/A
Urgent Care Facility	$50 copayment/visit	50% after deductible
Emergency Room (True Emergency)	$300 copayment, plus deductible and co-insurance ($300 copayment waived if admitted)	
Inpatient Hospital	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
MENTAL HEALTH		
Telehealth by AZ Blue	$25 copayment/visit	N/A
Inpatient & Substance Abuse Services	20% after deductible	50% after deductible
Outpatient Services	$25 copayment/visit	50% after deductible

BlueCross BlueShield of Arizona

Medical Network

It's important to verify providers are in your plan's network before you see them. Log in to www.azblue.com to find a provider in your network.

1. Click "Find Care" then "Browse the Network",
2. Type of Coverage is "Employer Provided", Type of Provider is "Medical" and Network is "Statewide/National PPO/EPO".
3. Choose your location and search

* Note Mayo Clinic AZ is out-of-network.

MEDICAL CLAIMS ADMINISTRATION

Administered by AmeriBen

After receiving services, in-network providers send a claim to BCBSAZ. BCBSAZ will reprice the claim based on their agreement with the provider. Once repriced, the claim is sent to AmeriBen for final processing. AmeriBen reviews the services billed to verify charges are payable for covered services. The provider will receive payment, and the participant receives an Explanation of Benefits (EOB) explaining how the claim was paid. For any claim or plan questions, please login to myAmeriBen.com or call AmeriBen at 1.855.258.6455.

MyAmeriBen.com

Your resource for claims, benefits, and eligibility information

To register online:

1. Visit 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 App

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.

PHARMACY BENEFITS

The prescription drug program is administered by SmithRx, who offers a national pharmacy network along with a variety of cost saving programs to enhance member experience and provide out-of-pocket savings. You are automatically enrolled in the prescription drug plan when you enroll in the medical plan.

	HDHP	PPO & PPO BUY-UP
Retail (up to 30 days)	0% after deductible	Generics: $15 copay Preferred Brand Name: $35 copay Non-Preferred Brand Name: $55 copay
Mail Order (90 days)	0% after deductible	Generics: $30 copay Preferred Brand Name: $80 copay Non-Preferred Brand Name: $130 copay
Specialty Drugs	0% after deductible	20% up to $300

What is Connect360?

Programs that help members access cost-saving options, often reducing medication costs to little or nothing. These programs include, but are not limited to, manufacturer coupon savings on traditional and specialty medications, and use of available advocacy foundations and grant programs to reduce costs when a high-cost specialty medication is not covered under the benefit, etc.

How Do I Learn More About My Prescription Benefits?

Your Prescription Benefit Coverage explains your plan's drug coverage, co-pays, and other key benefits in simple terms. If you have questions, contact SmithRx Member Services at 844-454-5201. You can also chat live with a member services representative on the website (www.smithrx.com) or in the member portal.

Formulary Facts

A formulary is a list of preferred, clinically reviewed medications—both generic and brand name—that your plan covers. It's updated regularly. To check if a drug is included, call the Member Services number on the back of your ID card or access it in the member portal at: www.smithrx.com/members.

What Mail Order Pharmacies are Available?

Amazon Pharmacy, Costco, Cost Plus Drug Company and Walmart Pharmacy.

Where Will I Get Specialty Medications?

Costco or Senderra.

Will I Still Be Subject to Plan/Medication Restrictions?

Yes, SmithRx utilizes a number of programs that you are likely familiar with such as Step Therapy and Prior Authorization.

IMPORTANT!

- Members who will experience disruption with the change in PBMs will be provided a grace period of 60 or 90 days after July 01, 2026 to refill affected medications. SmithRx will contact members via "snail" mail to advise of the disruption and provide alternatives for discussion with your physician. After the 3rd fill within the grace period, additional fills will be denied.
- SmithRx **requires** that members engage with Member Services to review disruption, cost saving programs, alternative delivery systems, etc. To avoid disruption of your ongoing medication regimen, please ensure you respond to mailed information and/or phone calls.
- NOTE: Effective July 01, 2026 members may now obtain prescriptions at CVS!

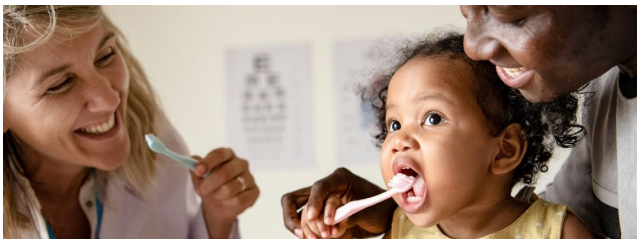
DENTAL BENEFITS

Administered by Delta Dental of AZ

Good oral care enhances overall physical health, appearance 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 regular dental care!

SERVICES	BASE PLAN (IN-NETWORK BENEFITS)	BUY-UP PLAN (IN-NETWORK BENEFITS)
Annual deductible (Individual / Family)	$50/$150	$50/$150
Annual Benefit Maximum	$2,000	$4,000
Preventive Dental Services (cleanings, exams, x-rays)	$0 deductible waived	$0 deductible waived
Basic Dental Services (fillings, root canal therapy, oral surgery)	20% after deductible	20% after deductible
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50% after deductible	50% after deductible
Orthodontia Services (Adult & Child)	50% after deductible	50% after deductible
Orthodontia Services	$2,000	$2,000
Child(ren) Eligibility	Age 19	Age 26

NOTE: If you elect the Base Plan and have a dependent who reaches age 19 during the plan year, that is not considered a qualifying event and you will not be allowed to elect the Buy-Up Plan mid year.



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** or calling **800.352.6132**.

VISION BENEFITS

Administered by VSP

Fountain Hills' 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.

SERVICE	BASE PLAN	BUY-UP PLAN
Eye Exam — once every 12 months	$10 copayment	$10 copayment
LENSES, CONTACTS AND FRAMES — ONCE EVERY PLAN YEAR		
Prescription Glasses	$20 copayment	$10 copayment
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
Progressive Lenses (Premium)	$25 copay	$25 copay
Frame Allowance	$150	$225
Contacts	$150	$175
Child(ren) Eligibility	Age 19	Age 26

NOTE: If you elect the Base Plan and have a dependent who reaches age 19 during the plan year, that is not considered a qualifying event and you will not be allowed to elect the Buy-Up Plan mid year.

VSP Extras – Hearing Aids

Save up to 60% on Hearing Aids!

TruHearing makes hearing aids affordable by providing exclusive savings to all VSP vision members. In addition to great pricing, TruHearing provides you with:

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

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

SPENDING ACCOUNTS

Fountain Hills offers tax-advantaged accounts to help you save on medical, dental, vision, and dependent care expenses. For more information on Spending Accounts and How the Plans Work, please refer to page 13.

HEALTH SAVINGS ACCOUNT (HSA)

Administered by Health Equity

A Health Savings Account (HSA) provides you with a tax advantage that can help you pay for certain expenses on a pre-tax basis. As an eligible employee, you agree to set aside a portion of your pre-tax salary in an HSA, and that money is deducted from each paycheck over the course of the plan year.

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

- Individual Coverage Contribution Maximum $4,400
- Family Coverage Contribution Maximum $8,750
- **Additional $1,000 contribution allowance if you will be 55 years or older by December 31.**

- Fountain Hills contributes $61.72 per month to your Employee only HSA account.

Note: You must be enrolled in the HDHP plan to be eligible for the HSA. If you are enrolled in Medicare, Medicaid, Tricare, a general-purpose health flexible spending account, have a health reimbursement arrangement, or can be claimed as someone else's tax dependent, by law you are not allowed to contribute to an HSA.

FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by Health Equity

FSAs allow you to save money by using pretax dollars to pay for eligible expenses. When you contribute to an FSA, your payroll deductions occur before federal income tax and Social Security tax, which lowers your taxable income and increases your take-home pay. You must enroll within 31 days of your eligibility date or during annual open enrollment, and you will choose your annual contribution amount at that time. Once enrolled, you can access your account information, balances, and reimbursement status at www.healthequity.com. A Healthcare FSA is used to pay for eligible medical, dental, and vision expenses for you and your dependents. These funds can help cover costs such as copayments, prescriptions, and other qualified healthcare expenses. A Healthcare FSA is strictly for medical-related use and is separate from the Dependent Care FSA.

A Dependent Care FSA is a different account designed specifically for eligible dependent day care expenses. This includes care for natural, adopted, or foster children under age 13, as well as for family members who live with you and cannot care for themselves. Funds in a Dependent Care FSA may be used for expenses such as licensed day care, before- and after-school programs, summer day camps, or adult day care. These expenses must relate to care, not healthcare, which is why this account operates independently from the Healthcare FSA.

Healthcare FSA Contribution Limit $3,400

Dependent Care FSA Limit $7,500 for married filing jointly or single; $3,750 for married filing separate.

Note: The FSA Medical and Dependent accounts are USE IT OR LOSE IT; any unused funds at the end of the run-out period will be forfeited. Further, this account does not have portability.

HOW THE PLANS WORK

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

With the HDHP, you pay the full negotiated cost for medical services and prescription drugs until you meet your out-of-pocket maximum. After that, the plan pays for 100% of your eligible claims for the rest of the plan year. There are no copays with this plan. Your paycheck deductions for this plan are lower than the PPO plans.

The PPO plans have set copays. You will pay 100% of your claims (plus copays) until you hit your deductible. Once you meet your deductible, you pay 20% of your claims (plus copays) until you meet your out-of-pocket maximum. After that, the plan pays for 100% of your eligible claims for the rest of the plan year. These plans have higher paycheck deductions than the HDHP plan.

PAYING FOR HEALTH CARE

Fountain Hills offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental, vision and dependent care expenses. The health care accounts available to you depend on the medical plan you choose. *Please see page 12 for more detail.

	HSA	MEDICAL FSA	DEPENDENT CARE FSA
What medical plan can I choose?	HDHP	PPO and PPO Buy-Up	All Plans
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)	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?	Funds are available as you contribute to the account	All of the funds you elect for the year are available on July 1	Funds are available as you contribute to the account
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	The IRS allows you to rollover $680 from 2026-27 to 2027-28. Funds rolled over must be used first in the next plan year.	No, any unused funds are forfeited
How do I pay for eligible expenses?	With your Health Equity debit card (You can also submit claims for reimbursement online at www.healthequity.com)		You will pay for your expenses out-of-pocket and then seek reimbursement. Instructions on reimbursements are located here at www.healthequity.com.
How much can I contribute each year?	$4,400 for individual coverage or $8,750 for family coverage	You can contribute up to $3,400 annually	$7,500 if you are married filing jointly or $3,750 if you are single
Can my employer contribute?	Yes, Fountain Hills contributes $61.72 per month for Employee Only HDHP coverage.	The employer does not contribute to the FSA account	The employer does not contribute to the FSA account
Can I change my contributions throughout the year?	Yes, contact Human Resources to change your HSA contributions at any time	No, unless you have a qualifying life event	No, unless you have a qualifying life event

2026-27 RATES AND CONTRIBUTIONS

Your benefit costs for the new plan year are listed below, reflecting both the employer contribution and your payroll deductions based on the coverage level you choose. Review the options carefully to understand how each plan fits your needs and budget.

PPO`	MONTHLY EMPLOYER CONTRIBUTION	MONTHLY EMPLOYEE CONTRIBUTION	EMPLOYEE CONTRIBUTION PER PAY PERIOD
Employee Only	$724.76	$0.00	$0.00
Employee + Spouse	$1,082.74	$360.92	$180.46
Employee + Child	$1,063.61	$265.90	$132.95
Employee + Family	$1,369.94	$587.12	$293.56
PPO BUY UP	**MONTHLY EMPLOYER CONTRIBUTION**	**MONTHLY EMPLOYEE CONTRIBUTION**	**EMPLOYEE CONTRIBUTION PER PAY PERIOD**
Employee Only	$724.26	$16.16	$8.08
Employee + Spouse	$1,082.74	$392.06	$196.03
Employee + Child	$1,063.60	$296.80	$148.40
Employee + Family	$1,369.93	$635.90	$317.95
HDHP	**MONTHLY EMPLOYER CONTRIBUTION**	**MONTHLY EMPLOYEE CONTRIBUTION**	**EMPLOYEE CONTRIBUTION PER PAY PERIOD**
Employee Only	$724.76	$0.00	$0.00
Employee + Spouse	$1,082.73	$219.08	$109.54
Employee + Child	$1,063.61	$134.32	$67.16
Employee + Family	$1,369.94	$399.20	$199.60
DENTAL BASIC	**MONTHLY EMPLOYER CONTRIBUTION**	**MONTHLY EMPLOYEE CONTRIBUTION**	**EMPLOYEE CONTRIBUTION PER PAY PERIOD**
Employee Only	$40.96	$0.00	$0.00
Employee + Spouse	$59.14	$19.72	$9.86
Employee + Child	$63.55	$24.72	$12.36
Employee + Family	$83.30	$46.86	$23.43
DENTAL BUY UP	**MONTHLY EMPLOYER CONTRIBUTION**	**MONTHLY EMPLOYEE CONTRIBUTION**	**EMPLOYEE CONTRIBUTION PER PAY PERIOD**
Employee Only	$40.95	$1.46	$0.73
Employee + Spouse	$59.14	$22.66	$11.33
Employee + Child	$63.55	$32.52	$16.26
Employee + Family	$83.30	$58.50	$29.25

2026-27 RATES AND CONTRIBUTIONS

Your benefit costs for the new plan year are listed below, reflecting both the employer contribution and your payroll deductions based on the coverage level you choose. Review the options carefully to understand how each plan fits your needs and budget.

VISION BASIC	MONTHLY EMPLOYER CONTRIBUTION	MONTHLY EMPLOYEE CONTRIBUTION	EMPLOYEE CONTRIBUTION PER PAY PERIOD
Employee Only	$7.98	$0.00	$0.00
Employee + Spouse	$13.72	$3.86	$1.93
Employee + Child	$11.63	$3.88	$1.94
Employee + Family	$16.25	$8.74	$4.37
VISION BUY UP	MONTHLY EMPLOYER CONTRIBUTION	MONTHLY EMPLOYEE CONTRIBUTION	EMPLOYEE CONTRIBUTION PER PAY PERIOD
Employee Only	$7.97	$3.50	$1.75
Employee + Spouse	$13.72	$12.02	$6.01
Employee + Child	$11.63	$12.22	$6.11
Employee + Family	$16.25	$22.52	$11.26

2026-27 RATES AND CONTRIBUTIONS

2026-2027 Premium Rates

Medical Benefit Costs

	Town Monthly Contribution*	Town HSA Monthly Contribution	Employee Monthly Contribution	Employee Per Paycheck
High Deductible Health Plan				
HDHP-Employee Only	$724.76	$61.72	$0.00	$0.00
HDHP-Emp+Spouse	$1,082.73	$0.00	$219.08	$109.54
HDHP-Emp+Children	$1,063.61	$0.00	$134.32	$67.16
HDHP-Emp+Family	$1,369.94	$0.00	$399.20	$199.60
PPO Plan				
PPO-Employee Only	$724.76	$0.00	$0.00	$0.00
PPO-Emp+Spouse	$1,082.74	$0.00	$360.92	$180.46
PPO-Emp+Children	$1,063.61	$0.00	$265.90	$132.95
PPO-Emp+Family	$1,369.94	$0.00	$587.12	$293.56
Buy-Up PPO Plan				
PPO Buy Up Employee Only	$724.76	$0.00	$16.16	$8.08
PPO Buy Up Emp+Spouse	$1,082.74	$0.00	$392.06	$196.03
PPO Buy Up Emp+Children	$1,063.60	$0.00	$296.80	$148.40
PPO Buy Up Emp+Family	$1,369.93	$0.00	$635.90	$317.95

* Includes applicable HSA contribution

Dental Benefit Costs

	Town Monthly Contribution	Employee Monthly Contribution	Employee Per Paycheck
Standard Dental Plan			
Employee Only	$40.96	$0.00	$0.00
Emp+Spouse	$59.14	$19.72	$9.86
Emp+Children	$63.55	$24.72	$12.36
Emp+Family	$83.30	$46.86	$23.43
Buy-Up Dental Plan			
Buy Up Employee Only	$40.95	$1.46	$0.73
Buy Up Emp+Spouse	$59.14	$22.66	$11.33
Buy Up Emp+Children	$63.55	$32.52	$16.26
Buy Up Emp+Family	$83.30	$58.50	$29.25

Vision Benefit Costs

	Town Monthly Contribution	Employee Monthly Contribution	Employee Per Paycheck
Vision Plan			
Employee Only	$7.98	$0.00	$0.00
Emp+Spouse	$13.72	$3.86	$1.93
Emp+Children	$11.63	$3.88	$1.94
Emp+Family	$16.25	$8.74	$4.37
Buy-Up Vision Plan			
Buy Up Employee Only	$7.97	$3.50	$1.75
Buy Up Emp+Spouse	$13.72	$12.02	$6.01
Buy Up Emp+Children	$11.63	$12.22	$6.11
Buy Up Emp+Family	$16.25	$22.52	$11.26

LIFE INSURANCE BENEFITS

Administered by Ochs

Fountain Hills provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance at no cost to eligible employees. All benefit-eligible employees are automatically enrolled in this coverage. The City also provides the option to enroll in Voluntary Term Life.

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides full-time employees Basic Term Life coverage in the amount of 1x your annual salary up to $250,000 maximum.	Elect in $10,000 increments up to $750,000.
Accidental Death & Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage equal to one time the employee's life benefits.	Elect in $10,000 increments up to $500,000
Spouse Benefit	N/A	Elect in $5,000 increments up to $250,000 not to exceed 100% of employee's total basic life coverage.
Child Benefit	N/A	Elect $2,500, $5,000, $7,500, $10,000 or $15,000, for each of your dependent children from live birth to age 26. One premium insures all children.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount when you sign up for coverage during the initial enrollment period.	Basic Life is guaranteed issue for new hires. No health questions are required.	Securian is offering a one-time open enrollment opportunity to add or elect $10,000 to current employees who have not elected $300,000 or more of coverage. Amounts requested over guaranteed issue are subject to medical underwriting.
Premiums	Covered by Fountain Hills	Rates are based on 5-year age bands according to your age as of July 01.
Benefit Reductions	Benefit will reduce to 50% of the amount otherwise provided for members 75 or older.	No age reduction for spouses.

Line of Duty Coverage

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

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. See Human Resources to obtain the form.

SUPPLEMENTAL LIFE INSURANCE RATES

Administered by Ochs

Rates per $1,000 per month				
Age	Supplemental	Spouse	Child	Voluntary AD&D
0-25	$0.060	$0.049	$.013 per $1,000 and one premium covers all children enrolled and the benefit payable is for each child.	$.003 per $1,000 for Employee Only coverage; $.045 for Family Coverage (Family benefit is a % of the employee's elected AD&D amount)
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

KEY POINTS TO CONSIDER ABOUT LIFE INSURANCE

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

DISABILITY INSURANCE

If you have questions about your disability benefits or need assistance with your coverage, please reach out to your Human Resources department or Mutual of Omaha.

SHORT TERM DISABILITY INSURANCE

Administered by Mutual of Omaha

Short-term disability coverage through Mutual of Omaha provides income protection if you are unable to work due to a non-work-related illness, injury, or pregnancy. After meeting the required waiting period, the plan pays a portion of your weekly earnings for a set duration, helping you maintain financial stability while you recover. Mutual of Omaha manages all claims and supports you throughout the process to ensure you receive benefits promptly and efficiently. Start your STD claim with Mutual of Omaha at www.mutualofomaha.com/support/forms.

LONG TERM DISABILITY INSURANCE

Administered by Mutual of Omaha

Mutual of Omaha also offers Long-Term Disability coverage for employees who are unable to work for an extended period of time due to a chronic illness or debilitating injury

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
Short-Term Disability	You receive 60% of your weekly salary up to a maximum of $2,500. Benefits begin after 30 calendar days and may continue for up to 13 weeks.	Fountain Hills
Long-Term Disability	You will receive 60% of your before-tax monthly earnings up to a maximum of $6,000. Benefits begin on the later of 90 calendar days or the date your short-term disability ends. Maximum benefit period depends on your age at disability; please refer to your Certificate Summary for details.	

ADDITIONAL BENEFITS

Employee Assistance Program

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

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

- Stress, depression, anxiety;
- Relationship issues, divorce;
- Job stress, work conflicts;
- Family and parenting problems;
- Financial and Legal information; 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.supportlinc.com**

Gallagher | Marketplace

The Gallagher Marketplace offers significant savings on things you are already buying – like pre-paid legal services, identity theft protection, pet insurance, renter's insurance, boat/RV insurance, as well as extended vehicle warranties and an employee discount program – all in one centralized hub.

How it works:

- Visit https://www.ajg.com/gallagher-marketplace/ to see your available benefits.
- Select a product to view more details
- Click on the partner link to learn more, get a free no-obligation quote or apply for coverage.
- Enter AzMT when prompted.

Scan the QR code to learn more.

Telemedicine

New Provider!

Administered by Telehealth by AZ Blue

BlueCross BlueShield Arizona

Avoid expensive emergency room visits by using Telehealth by AZ Blue. The average cost of an E.R. visit is $2,283. You may be responsible for a copayment, deductible and coinsurance depending on which plan you are enrolled in so it may cost you between $550 to $2,283.

Discover the convenience, comfort, and savings of Telehealth.

If you don't have a regular doctor, or if your primary care provider isn't available, you can visit with a board-certified doctor in the privacy and comfort of home. See a doctor, counselor, or psychiatrist from your phone, computer, or tablet. You can get the care you need—from wherever you are. Plus, Telehealth visits often cost less than an urgent care visit.

	PPO Plans	HDHP
General Health	$25 copay	$69 Consultation Fee
Counseling	$25 copay	Between $121-$145 Consultation Fee
Psychiatry	$25 copay	$267 Initial Visit Between $101-$150 Consultation Fee Ongoing

What services are offered?

Medical

Get treated for minor injuries and illnesses and non-emergency health issues like cold and flu symptoms, fevers, rashes, and stomach bugs. Doctors can also prescribe medications from your pharmacy of choice, if needed.

Counseling

You can get the benefits of an in-person counseling session online. Schedule an appointment with a board-certified counselor or psychologist to get help for depression and anxiety, as well as stress caused by grief, divorce, parenting challenges, job loss, and other major life changes.

Psychiatry

A board-certified psychiatrist is available by appointment. Experienced psychiatrists can help you address common behavioral health challenges, and provide assessments and treatments, as well as assist with medication management.

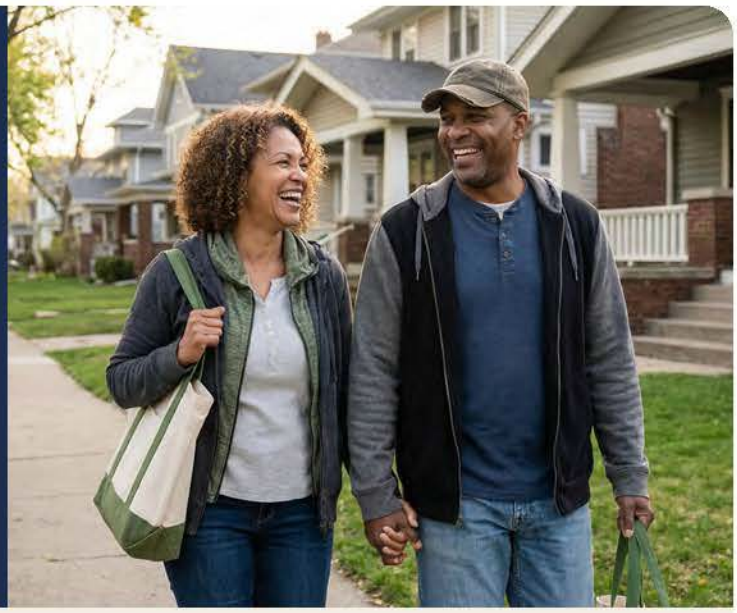
Sign up to get started.

Visit AZBlueTelehealth.com and follow the prompts to set up your access.
Note: AzMT Members must use the direct link, AZBlueTelehealth.com, to access care.

Leap

Infusion care made easier

With Leap, you get infusion care that fits your life.



Convenient infusion care

Receive infusion therapy from the comfort of home or at a preferred clinic nearby. No more long hospital visits or commutes.

Dedicated support

Your dedicated Leap Care Guide works with you to understand your needs, answer questions, and coordinate care, so you have less to worry about.

Fast, flexible scheduling

Choose times that work best for you, including evenings and weekends. Treatment can usually be scheduled within a week.

Cost savings

Unlike many hospitals and doctors' offices, Leap doesn't mark up medication costs, so you and your plan save more.

"Having care come to my home changed everything. Treatment no longer feels like something that takes over my life. Instead, it fits into my routine and gives me back valuable time to spend with the people I love."

— Alice, Leap member

Learn more at **leaphealth.com/patients**

Or, call or text us at (929) 998-8932

Leap

Frequently asked questions

What is Leap?

Leap is a national coordinator of infusion care that works with members to deliver care at home or at a local infusion clinic.

Who can use Leap?

When an employer partners with Leap, employees and their covered dependents enrolled in the employer's medical plan gain access to Leap. A Leap Care Guide can confirm whether a specific prescribed treatment is a good fit for Leap.

How much does Leap cost?

Leap works directly with your employer to provide eligible members coverage and is typically the lowest cost option for infusion treatments. Unlike many hospitals and doctors' offices, Leap doesn't add extra charges to medication costs. Instead, we negotiate the best prices on your medications and pass on the savings directly to you and your employer. For more details, please check your benefit plan.

What treatments does Leap support?

Leap coordinates infusion treatments for a wide range of conditions and therapies, including (but not limited to) multiple sclerosis, lupus, chronic inflammatory disorders, Crohn's disease, chronic kidney disease, bleeding disorders, hematology, immunoglobulins, and some oncology treatments. To learn whether your treatment qualifies, please contact us.

Is home infusion safe?

Yes. Home infusion is a well-established practice supported by decades of clinical evidence. Leap only offers home infusion when it is clinically appropriate, according to evidenced-based guidelines. We partner with licensed infusion nurses who are trained to give IVs, watch for reactions, and oversee the safety of your treatment, just like in a clinic. Whenever possible, you'll see the same nurse for a familiar, personalized experience.

Who will I connect with at Leap?

Your Leap Care Guide will be your dedicated point of contact. They'll schedule your appointment, answer any questions, and coordinate with your doctor, insurance, and pharmacy.

What if I'm not eligible for home treatment?

Leap coordinates care using evidence-based guidelines. If you are not an optimal candidate for in-home care — or you prefer to go to a clinic — Leap will coordinate care to an accredited, in-network infusion center within a reasonable distance of your home.

Learn more at **leaphealth.com/patients**

Or, call or text us at (929) 998-8932

Wellness Program Overview

AzMT offers a comprehensive Wellness Program, AzMT L.I.V.E. (Live. In. Vitality. Everyday.), 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 with 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

SWORD - DIGITAL PHYSICAL THERAPY

Thrive

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, menopause, and post-menopause.

WELLNESS PORTAL THROUGH PERSONIFY HEALTH!

Personify Health 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 in Personify Cash every year!

Use these rewards to shop in the Personify Health Store.
Sign up using the link:
https://enroll.personifyhealth.com/#/enrollmentGroups/00923931-98ad-4352-934b-83cbf734750b/step/1
or scan the QR code!

MONTHLY NEWSLETTER

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

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

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

For questions, please reach out to HR.

AzMT L.I.V.E.

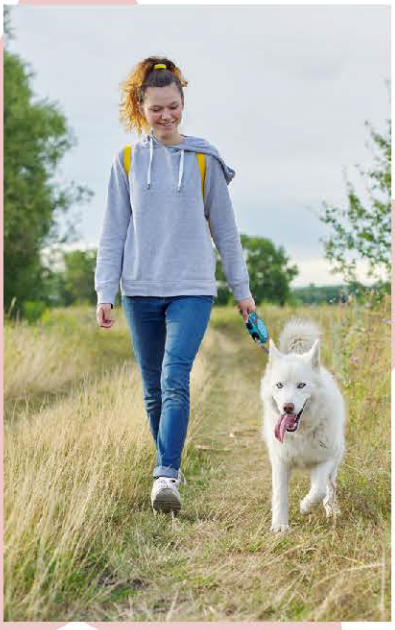
PREVENTIVE SCREENINGS AND SERVICES

As part of the AzMT Wellness Program, preventive screenings and services are brought onsite to provide members with 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 for the 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.

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 HR.

Complete a coaching session to earn 500 pts 1x per month.

Health coaching guide

Let's face it. Getting healthier can be challenging! But now you can request one-on-one support from a qualified coach—right from our website or app. A coach can motivate you, give you tips and help you reach your goals. What are you waiting for? Start working with a coach today!

Not a member yet?

Don't miss out on all the fun! Get started today by going to **join.personifyhealth.com/companyname**.

Schedule a session today!

Visit **app.personifyhealth.com**, go to the **Health** tab and select **Coaching**, or scan the QR code to open in the app.

AzMT ARIZONA Metropolitan Trust

personify HEALTH

Maternal Health

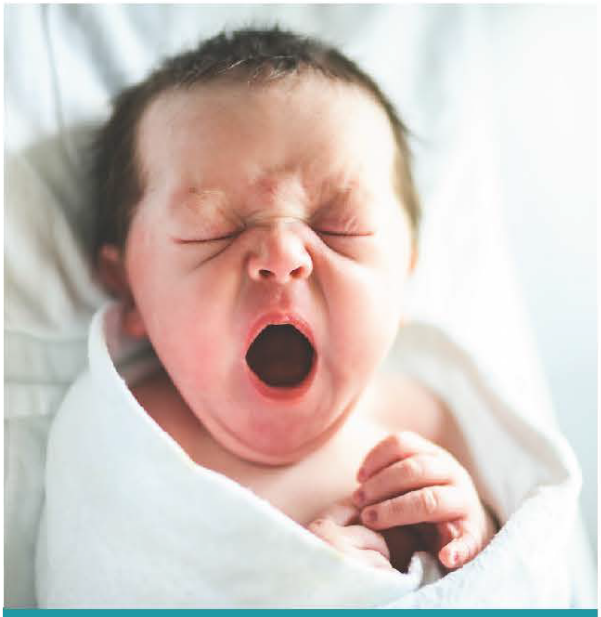
Navigate Pregnancy with Confidence through Baby Steps

Pregnancy is a journey filled with both joy and unexpected challenges. While surprises may arise, Baby Steps is here to provide peace of mind and support every step of the way. We connect you with essential resources, tools, and answers to help ensure a healthy pregnancy and delivery for you and your baby.

We offer personalized support through our maternal health registered nurse, who will assist you in maintaining health and avoiding complications during and after your pregnancy.

Getting Started with Baby Steps

Included in your Arizona Metropolitan Trust health plan, Baby Steps gives you educational resources like a free copy of "What to Expect When You're Expecting!" Plus, your dedicated nurse will help you find in-network providers and understand your prenatal tests and results. Reach out whenever you need guidance, reassurance, or just a bit more support.



AmeriBen is here to help you every step of the way on your pregnancy journey.

- Call: 855-778-9053
- Visit: myameriben.com
- Email: MaternalHealth@ameriben.com

AmeriBen

AzMT ARIZONA Metropolitan Trust

AmeriBen is a separate and independent company providing medical benefits administration services on behalf of self funded group health plans.

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, Gallagher Benefit Services, or Administration.

BENEFIT	VENDOR	PHONE	WEBSITE OR EMAIL
Medical Claims Administrator	AmeriBen	855-350-8699	www.MyAmeriBen.com
Medical Review	AmeriBen	855-778-9053 Fax 833-730-7961	www.MyAmeriBen.com
Medical Network	Blue Cross Blue Shield of Arizona	800-232-2345	www.azblue.com
Telemedicine	Telehealth by AZ Blue	844-606-1612	AZBlueTelehealth.com
Prescription	SmithRx	844-454-5201	help@smithrx.com
Dental	Delta Dental of AZ	800-352-6132	www.deltadentalaz.com
Vision	VSP	800-877-7195	www.vsp.com
Flexible Spending and Health Savings Accounts	Health Equity	866-382-3510 HSA 855-428-0447 FSA	www.healthequity.com
Life and AD&D	Ochs/Securian	800-392-7295	www.ochsinc.com
Short- and Long-Term Disability	Mutual of Omaha	800-655-5142	www.mutualofomaha.com
Infusion Care Program	Leap Health	929-998-8932	www.leaphealth.com
Employee Assistance Program	Supportlinc	888-881-5462	www.supportlinc.com
Thrive	Sword	-	sword.health/thrive/cct/go
Bloom	Sword	-	sword.health/bloom/cct/go
Plan Administrator	Gallagher Benefit Services	928-391-2297	Jaime_Schulenberg@ajg.com
Fountain Hills HR	Jinnett Hancock	480-816-5124	jhancock@fountainhillsaz.gov

Legal Notices & Disclosures

PATIENT PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

You are protected from balance billing for:

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in you explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed you may contact the No Surprises Help Desk (NSHD) at www.cms.gov/nosurprises or call 800.985.3059 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 or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

HIPAA NOTICE OF PRIVACY PRACTICES
YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. **Please review it carefully.**

If you have any questions about this Notice please contact
Arizona Metropolitan Trust's Privacy Officer
c/o Gallagher Benefit Services
8800 E. Raintree Dr., Ste. 250
Phoenix, AZ 85260
(p) 928.391.2297 (f) 928.391.2310
Email: Jaime_schulenberg@ajg.com

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll

- Provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on Page 1 of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- of that coverage. This does not apply to long term care plans.
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price *Example: We use health information about you to develop better services for you.*

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And **in all cases,** if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This notice was updated February 16, 2026

ADDITIONAL PRIVACY FOR REPRODUCTIVE HEALTHCARE

Federal law prohibits us from using or disclosing your information when it is being sought to investigate or impose liability on you, health care providers, or others who seek, obtain, provide or facilitate lawful reproductive health care, or to identify persons for such activities. This prohibition applies where we, or others acting on our behalf, have reasonably determined that: (1) The reproductive health care is lawful under the law of the state in which it was provided under the circumstances in which it was provided, for example, if a resident of one state traveled to another state to receive reproductive health care, such as an abortion, that is lawful in the state where such health care is provided; or (2) The reproductive health care is protected, required, or authorized by Federal law, including the U.S. Constitution, regardless of the state in which such health care is provided, for example, if the use of the reproductive health care, such as contraception, is protected by the Constitution; or (3) The reproductive health care was not provided by us, but we presume it was lawful.

However, if we receive a request for your information, and we have actual knowledge that the reproductive health care was not lawful under the circumstances under which it was provided to you, this presumption does not apply. For example, if you tell us you received reproductive health care from an unlicensed person and we know that the specific reproductive health care must be provided by a licensed health care provider.

When we receive a request for your information potentially related to reproductive health care, we must obtain a signed attestation from the requester that the use or disclosure is not for prohibited purposes when the request relates to health oversight activities, judicial and administrative proceedings, law enforcement purposes, and disclosure to coroners and medical examiners. For example, if we receive a lawful subpoena for medical records that include information related to reproductive healthcare, we must obtain signed attestation from the requester that states the request is not for a prohibited purpose.

HIPAA Special Enrollment Rights

Arizona Metropolitan Trust Notice of Your HIPAA Special Enrollment Rights

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

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

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

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

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

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

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

Important Warning

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

NOTICE OF CREDITABLE COVERAGE

Important Notice from AzMT
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with AzMT and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current AzMT coverage will not be affected.

Your current AzMT medical coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare drug plan, you will still be eligible to receive medical and prescription drug benefits through AzMT. If you do enroll in a Medicare drug plan, in general, the following guidelines apply:

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

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

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

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

You should also know that if you drop or lose your current coverage with AzMTand 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 41, for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through AzMT changes. You may also request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1 800-772-1213 (TTY 1-800-325-0778).

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

Name of Entity/Sender:	**Arizona Metropolitan Trust**
Contact—Position/Office:	**Jaime Schulenberg, Pool Administrator**
Office Address:	**c/o Gallagher Benefit Services** **8800 East Raintree Dr., Suite 250** **Scottsdale, AZ 85260**
Phone Number:	**928-391-2297**

WELLNESS PROGRAM DISCLOSURE: ALTERNATIVE STANDARD

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

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

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

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

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

NOTICE REGARDING WELLNESS PROGRAM

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

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

Additional incentives of Personify 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, Personify 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 Daniela Zubic, Wellbeing Consultant, at Daniela_Zubic@ajg.com.

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

Protections from Disclosure of Medical Information

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

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

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

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

COBRA GENERAL NOTICE

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan contact information

Name of Entity:	Arizona Metropolitan Trust (AzMT)
Contact Person:	Jaime L. Schulenberg, Pool Administrator
Address:	c/o Gallagher Benefit Services 8800 East Raintree Dr., Suite 250 Scottsdale, AZ 85260
Phone Number:	928-391-2297

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

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

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

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

- Cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage;
- Cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability;
- Cause claims to not be able to be considered for payment until eligibility issues have been resolved; or
- Result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and/or vision benefits.

Disclaimer

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

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting