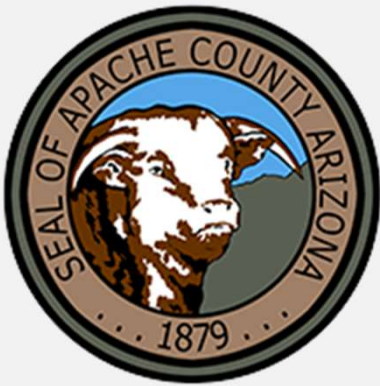
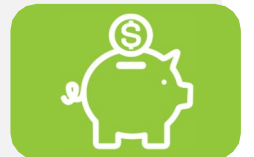


# 2026-27 BENEFITS GUIDE



## Apache County

July 1, 2026 – June 30, 2027





# BENEFITS OVERVIEW

Apache County is proud to offer a comprehensive benefits package to full-time employees. The complete benefits package is briefly summarized in this booklet. You share the costs of some benefits (medical, dental and vision), and Apache County provides other benefits at no cost to you (life, accidental death & dismemberment, short-term disability). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

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## BENEFITS OFFERED

- Medical
- Dental
- Vision
- Flexible Spending Account (FSA)
- Health Savings Account (HSA)
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short-Term Disability
- Long Term Disability
- Employee Assistance Program
- Wellness program
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Gallagher Marketplace


## ELIGIBILITY

You and your legal dependents are eligible for benefits on the first of the month following thirty (30) days from date of hire.

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

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 31 days of qualifying event.

**If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 49 for more details.**



The cost of healthcare continues to be significant. To help control healthcare costs, utilize AZBlue Telehealth and urgent care instead of the emergency room (when appropriate), choose generic medications, and participate in on-site preventive screenings offered by the wellness program.

This document is an outline of the coverage provided under your employer’s benefit plans based on information provided by your company. 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/Benefits Department.



## IMPORTANT DATES & INFORMATION

### OPEN ENROLLMENT DATES:

Begins at 12:01 AM Monday, April 27, 2026 – Ends Thursday, May 21, 2026 at 5:00 PM – Arizona Time

### BENEFIT ENROLLMENT

All eligible employees wishing to make benefit election changes should do so during the open enrollment period from **Monday, April 27 to Thursday, May 21, 2026** in the PlanSource Portal. If you do not make changes, your current elections will stay in effect for the 2026-27 plan year. If enrolling in the FSA, you will need to make that election in the PlanSource portal even if you are not making any other changes.

### DEPENDENT ELIGIBILITY & VERIFICATION:

Employees who wish to add dependents to the health, dental, or vision plans for the 2026-27 plan year will be required to provide documentation that the person being enrolled is an eligible dependent as defined by the plan. Examples include marriage certificate, and an additional document dated within the last 60 days (mortgage statement, lease agreement, auto loan/gas/electric bill, etc.), birth certificates, court orders regarding custody or guardianship, or any other documents that verify dependent status. Failure to submit this information during your initial enrollment or open enrollment, as applicable, will result in your dependents being dropped from the benefit plans. Please see Human Resources for a full list of acceptable documents to show Dependent Eligibility.

### MEMBER ID CARDS:

**Medical/Prescription Cards** – Members will be receiving new Medical ID Cards for the upcoming Plan Year. Until the new cards are received, Members should retain their current AmeriBen medical/prescription ID card.

Alternatively, Members have access to an electronic ID card through AmeriBen's website at [www.MyAmeriBen.com](http://www.MyAmeriBen.com). If you need an additional medical/prescription card, register or log in [www.MyAmeriBen.com](http://www.MyAmeriBen.com) to submit a request or call AmeriBen Customer Care Center at 1-877-635-2912.

**Dental and/or Vision Cards** – Members should retain their current dental and/or vision cards. Only those who elect new coverage will receive a new dental and/or vision card. If you need an additional dental/vision card, register, or log in to [www.ameritas.com](http://www.ameritas.com) to submit a request or call Ameritas Customer Care Center at 1-800-487-5553.



# BENEFIT CHANGES EFFECTIVE JULY 01, 2026

## ADMINISTRATIVE

Medical/Rx Re-card for all Employees  
 Transition Pharmacy Benefit Manager from Navitus to SmithRx  
 Add Leap Health  
 Transition Mental Health/Substance Abuse Precertification and Case Management from Jorgensen Brooks to American Health Group  
 Add Gallagher MarketPlace

## MEDICAL – PPO

Add Coverage through the BCBS BlueCard for 49 Other States  
 Remove PHCS and HMN Networks  
 Replace Teladoc with AZBlue Telehealth  
 Increase In-Network Deductible from \$500 to \$600 per plan participant  
 Increase Non-Network Deductible from \$1,500 to \$1,800 per plan participant  
 Increase Out-of-Pocket Maximum from \$5,500 EE/\$14,300 EF to \$7,000 EE/\$18,200 EF  
 Increase Specialist Copay from \$45 to \$50






## MEDICAL – HDHP

Add Coverage through the BCBS BlueCard for 49 Other States  
 Remove PHCS and HMN Networks  
 Replace Teladoc with AZBlue Telehealth  
 Increase In-Network Deductible/Out-of-Pocket Maximum from \$3,750 EE/\$7,500 EF to \$4,000 EE/\$8,000 EF  
 Increase Out-of-Network Deductible from \$7,000 EE/\$14,000 EF to \$8,000 EE/\$16,000 EF  
 Increase Out-of-Network Out-of-Pocket Maximum from \$14,000 EE/\$28,000 EF to \$16,000 EE/\$32,000 EF



# CHOOSING THE RIGHT CARE

## Quick reference guide for medical treatment options:

	Hours	Your Relative Cost *	Description
<b>AmeriBen</b> Customer Care 	6 a.m. - 6 p.m. MT	No additional cost to you.	Assistance with finding care, benefits questions, claims status, digital ID cards, and any other questions that arise concerning care. <b>877-635-2912</b>
<b>American Health Group</b> Case or Health Management RN	Monday- Friday 8 am - 5 pm	No additional cost to you	Assistance in navigating the healthcare system. We help you understand your condition, answer your health-related questions, facilitate quality care, and help you manage your healthcare costs. <b>800-847-7605</b>
<b>Doctor's Office</b> 	Office hours vary - need an appointment	Usually lower out-of-pocket costs to you than urgent care	It is important that you establish care with a primary care provider to manage your care. Your provider's office is generally the best place to go for non-emergency care such as health exams, colds, flu, sore throats, and minor injuries.
<b>AZBlue Telehealth</b> 	24 hours, 7 days a week	Usually lower out-of-pocket costs to you than urgent care	24/7 access to a provider via online video consultations. Can be accessed from anywhere you are. Average call back time is under 10 minutes. Provides services for problems such as colds, flu, bronchitis, allergies, ear/sinus/respiratory infections, urinary tract infections, dermatologic conditions <a href="http://www.azbluetelehealth.com">www.azbluetelehealth.com</a>
<b>Retail Health Clinic</b>	Similar to Retail Store hours	Usually lower out-of-pocket costs to you than urgent care	Walk-in clinics are often located in stores or pharmacies to provide convenient, low-cost treatment for minor medical problems such as ear infections, colds/flu, bronchitis, and some vaccinations.
<b>Urgent Care Provider</b> 	Generally, includes evenings, weekends, and holidays	Usually lower out-of-pocket costs to you than an ER visit	Urgent Care Centers can provide care when your doctor is not available for non-emergency services, but when immediate care is needed for conditions such as sprains, fevers, minor cuts, and injuries.
<b>Emergency Room (ER)</b> 	24 hours, 7 days a week	Highest out-of-pocket cost to you	For medical emergencies, call 911 or local emergency services first. Any life threatening or disabling condition, sudden/unexplained loss of consciousness, chest pain, numbness in face/arm/leg, difficulty speaking, severe shortness of breath, high fever with stiff neck/ confusion or difficulty breathing, coughing up or vomiting blood, cut or wound that won't stop bleeding, major injuries, possible broken bones.

\*Relative costs described are for in-network providers. Your costs for out-of-network providers may be significantly higher.

\*\* Preventive services are covered with no cost sharing when delivered by in-network providers. Certain services have age-specific requirements.

If you do not currently have a Primary Care Provider, we can assist you with finding an in-network provider by calling our Customer Service team at **877-635-2912**.



# 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.

## HIGH-DEDUCTIBLE HEALTH PLAN (HDHP) OUTLINE OF BENEFITS

MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
<b>Plan Year Deductible</b>		
Per Person	\$4,000	\$8,000
Family Maximum	\$8,000	\$16,000
<b>Out-of-pocket Maximum</b>		
Per Person	\$4,000	\$16,000
Family Maximum	\$8,000	\$32,000
	(Includes deductible)	(Includes deductible)
<b>Inpatient Hospital</b>	100% after deductible	50% after deductible
<b>Outpatient Facility</b>	100% after deductible	50% after deductible
<b>Office Visits</b>	100% after deductible	50% after deductible
<b>Urgent Care Facility</b>	100% after deductible	50% after deductible
<b>Preventive Services</b> (services as required by law as well as routine physicals and all AZLGEBT onsite screenings)	100% no deductible	Not Covered
<b>Chiropractic Care</b> (limited to 26 visits and \$40 eligible charge per visit)	100% after deductible	50% after deductible
<b>X-ray/Lab</b> (in office)	100% after deductible	50% after deductible
<b>X-ray/Lab</b> (outpatient facility)	100% after deductible	50% after deductible
<b>Maternity</b>	100% after deductible	50% after deductible
<b>Emergency Room</b>	100% after deductible (waived if admitted)	100% after deductible (waived if admitted)
<b>Behavioral/Mental Health and Substance Use Disorders – Inpatient</b> (includes residential treatment)	100% after deductible	50% after deductible
<b>Behavioral/Mental Health and Substance Use Disorders – Outpatient</b> (includes partial hospitalization)	100% after deductible	50% after deductible
<b>Prescription Drugs</b> (The deductible is waived for smoking cessation drugs, prescribed preventive medications, and contraceptives as required by federal law)	100% after deductible Available only through SmithRx participating specialty pharmacies	Not Covered
<b>Telemedicine/AZBlue Telehealth</b>	\$0 deductible waived	
<b>Employee Assistance Program (EAP)</b>	6 visits per issue	



# MEDICAL BENEFITS

Administered by AmeriBen and BCBSAZ

PPO PLAN OUTLINE OF BENEFITS		
MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
<b>Plan Year Deductible</b> Per Person	\$600	\$1,800
<b>Out-of-pocket Maximum</b> Per Person Family Maximum	\$7,000 \$18,200 (Includes deductible)	Unlimited Unlimited (Includes deductible)
<b>Inpatient Hospital</b>	80% after deductible	50% after deductible
<b>Outpatient Facility</b>	80% after deductible	50% after deductible
<b>Office Visits</b> Primary Care Specialist	\$30 co-pay \$50 co-pay	50% after deductible 50% after deductible
<b>Urgent Care Facility</b>	\$50 co-pay	50% after deductible
<b>Preventive Services</b> (services as required by law as well as routine physicals and all AZLGEBT onsite screenings)	100% no deductible	Not Covered
<b>Chiropractic Care</b> (limited to 26 visits and \$40 eligible charge per visit)	\$30 co-pay	50% after deductible
<b>X-ray/Lab</b> (in office) Primary Care Specialist	\$30 co-pay \$50 co-pay	50% after deductible 50% after deductible
<b>X-ray (outpatient facility)</b>	\$30 co-pay	50% after deductible
<b>Lab</b> (outpatient facility)	\$30 co-pay if under \$500 80% after deductible	50% after deductible
<b>Maternity</b>	80% after deductible	50% after deductible
<b>Emergency Room</b>	\$150 copay then 80% after deductible (waived if admitted)	\$150 copay then 80% after deductible (waived if admitted)
<b>Behavioral/Mental Health and Substance Use Disorders – Inpatient</b> (includes residential treatment)	80% after deductible	50% after deductible
<b>Behavioral/Mental Health and Substance Use Disorders – Outpatient</b> (includes partial hospitalization)	80% after deductible	50% after deductible
<b>Telemedicine/AZBlue Telehealth</b>	\$0	
<b>Employee Assistance Program (EAP)</b>	6 visits per issue	



# 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.



**BlueCross  
BlueShield  
of Arizona**



## ARIZONA AND NATIONWIDE MEDICAL NETWORK

It's important to verify providers are in your plan's network before you see them. If you have a HDHP, providers who are not in your plan's network will cost you more. If you have a PPO plan, providers who are not in your plan's network will not be covered by your plan.

Log in to [www.azblue.com](http://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".
3. Choose your location and search

*Mayo Clinic may appear in your search results, but they continue to be excluded from in-network coverage*



# MEDICAL CLAIMS ADMINISTRATION

Administered by AmeriBen

After the doctor's visit, in-network providers send the price adjustment request to BCBSAZ. BCBSAZ will grant a price reduction based on the 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 into [myAmeriBen.com](http://myAmeriBen.com) or call Ameriben at 1.877.635.2912.

## MyAmeriBen.com

*Your resource for claims, benefits, and eligibility information*



To register online:

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

To register on MyAmeriBen

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.



# Telemedicine

Administered by AZBlue Telehealth

Avoid expensive emergency room visits by using AZBlue Telehealth. 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 \$500 to \$2,283. Compare this to \$0 for HDHP members or PPO members.

## Discover the convenience, comfort, and savings of AZBlue 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. So, you can get the care you need—from wherever you are. Plus, AZBlue Telehealth visits often cost less than an urgent care visit.

## 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.

	PPO	HDHP
General Health	\$0 copay	\$0 (Deductible waived)
Counseling	\$0 copay	\$0 (Deductible waived)
Psychiatry	\$0 copay	\$0 (Deductible waived)



# Telehealth from AZ Blue



## 1 Sign up to get started.

- Visit [azbluetelehealth.com](https://azbluetelehealth.com)
  - Follow the prompts to set up your access.
- Helpful hint:* Even if you have created an account before, you will be directed through prompts to re-register.



**AZLGEBT Members must use the direct link, [azbluetelehealth.com](https://azbluetelehealth.com), to access care.**

## 3 Make an appointment.

- Follow the steps to choose a provider for immediate care, or schedule an appointment for counseling or psychiatry.
- You can see the fees, and add or change your payment information.



If you are traveling out of state, you'll need to change your profile setting to show the state you're visiting. That way, you can choose a doctor who is licensed to practice in that state.

## 2 Know when to use it.

Visit with a doctor, counselor, or psychiatrist for help with:

- Cold, flu, fever
- Cough, bronchitis
- Diarrhea, vomiting
- Headache
- Pink eye
- Rashes
- Insomnia
- Anxiety
- Depression, and more



## 4 Get treated.



You will talk with the doctor about your health concern just like you would at a regular office visit.



The doctor will give you treatment options and may send a prescription to the pharmacy you've selected, if needed.



Need a "sick slip" or other document to go back to work or school? The doctor can provide one as appropriate.

**Note:** Visits are fully covered at 100% with no deductible. A payment method may be requested when booking a consultation, but the charge will be waived to \$0 unless the member fails to show up or cancels/reschedules less than 24 hours in advance.



# Precertification, Case Management and Patient Advocacy Program

Administered by American Health Group (AHG)

## Precertification

Some procedures, treatments, and services require prior authorization. AHG's clinical team determines medical appropriateness utilizing evidence-based medical review criteria. AHG also examines the proposed site of service and utilization of in-network based providers/facilities to the plan.

## Case Management

Services designed to help manage the care of plan participants who have complex, special, or extended care illnesses or injuries. Members who may be appropriate to receive services are contacted by AHG directly and are offered assistance in navigating their treatment. If you are dealing with a complex medical diagnosis or treatment plan and would like to receive the assistance of a nurse case manager, please reach out to AHG at 1.800.847.7605

**Effective 7/1/2026 Mental Health/Substance abuse precertification and Case Management will transition to AHG from Jorgensen Brooks.**

## Patient Advocacy

A Patient Advocate serves as your personal coach and will help support you throughout your healthcare journey. Patient Advocacy is a free benefit provided by your employer.

- Education
  - Ins and outs of health insurance to reduce costs
  - How to talk to your provider
  - Medical jargon
  - Explanation of benefits (EOB)
- Understanding
  - What requires pre-authorization
  - Who is an in-network doctor/facility
  - The cost difference between hospitals vs. free standing facilities
- Navigation
  - Avenues of financial assistance
  - Complicated billing issues
  - Community Resources

**American Health Group (AHG)**

**1.800.847.7605 / 602.265.3800**

[info@amhealthgroup.com](mailto:info@amhealthgroup.com)



# 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](https://leaphealth.com/patients)

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



# 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](https://leaphealth.com/patients)

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

# HOW THE PLANS WORK

Both plans use the Blue Cross Blue Shield of Arizona network and cover 100% of the cost for preventive care services like calendar year 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 calendar year deductible. After that, the plan pays for 100% of your claims for the rest of the year.

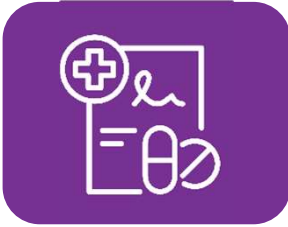
The **PPO plan** has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your calendar year out-of-pocket maximum.

	HDHP Plan	PPO Plan
<b>Monthly Cost for Coverage (Individual / Family)</b>	\$78 / \$256	\$78 / \$256
<b>Deductible (Individual / Family)</b>	\$4,000 / \$8,000	\$600
<b>Out-of-pocket Maximum (Individual / Family)</b>	\$4,000 / \$8,000	\$7,000 / \$18,200
<b>Spending Account Options</b>	Health savings account (HSA) Dependent care FSA	Health care FSA Dependent care FSA

## PAYING FOR HEALTH CARE

Apache County offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose. Please see page 19 for more detail.

	HSA	FSA
<b>What medical plan can I choose?</b>	HDHP	PPO plan
<b>What expenses are eligible?</b>	Medical, prescription, dental & vision care (See <a href="#">IRS publication 502</a> for the types of expenses that may be eligible)	Medical, prescription, dental & vision care (See <a href="#">IRS publication 502</a> for the types of expenses that may be eligible)
<b>When can I use the funds?</b>	Funds are available as you contribute to the account	All of the funds you elect for the year are available on the first payday after July 1
<b>Can I roll over funds each year?</b>	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	No, you will lose any funds remaining in your account at the end of the year, unless your plan has a grace period or carryover
<b>How do I pay for eligible expenses?</b>	With your Health Equity debit card (You can also submit claims for reimbursement online at <a href="http://www.healthequity.com">www.healthequity.com</a> )	With your Health Equity debit card (You can also submit claims for reimbursement online at <a href="http://www.healthequity.com">www.healthequity.com</a> )
<b>How much can I contribute each year?</b>	\$4,400 for individual coverage or \$8,750 for family coverage	You can contribute up to \$3,400 annually.
<b>Can my employer contribute?</b>	Yes, Apache County contributes up to \$660 for individual coverage or \$1,320 for family coverage	The employer does not contribute to the FSA account.
<b>Can I change my contributions throughout the year?</b>	Yes, you can change your HSA contributions at any time. Visit the HR Department for more information.	No, unless you have a qualifying life event



# PHARMACY BENEFITS

Administered by SmithRx

	HDHP		PPO PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
PHARMACY				
Expanded Preventive List Medications	Formulary medications appearing on the Expanded Preventive list are covered with \$0 member cost-sharing. This list is updated periodically by SmithRx. Log into your SmithRx account to review the list. <a href="http://www.SmithRx.com">www.SmithRx.com</a>		Preventive medications required by law are covered at \$0 member cost-sharing.	
Retail (up to 30 days)	Generic Drugs 100% after Deductible Formulary Brand Name Drugs 100% after Deductible Non-Formulary Brand Name Drugs 100% after Deductible		Generics \$15 copay Formulary Brand Name \$40 copay Non-Formulary Brand Name \$80 copay	
Mail Order (90 days)	Generic Drugs 100% after Deductible Formulary Brand Name Drugs 100% after Deductible Non-Formulary Brand Name Drugs 100% after Deductible		Generics \$30 copay Formulary Brand Name \$100 copay Non-Formulary Brand Name \$200 copay	
Specialty Drugs	100% after Deductible		\$100 copay	

## Formulary Facts

A formulary is a comprehensive list of preferred drugs chosen based on quality and efficacy by a committee of physicians and pharmacists. The drug formulary serves as a guide for the provider community by identifying drugs which are covered. It is updated regularly and includes both generic and brand name medications. You can find the AZ Local Government Employee Benefit Trust (AZLGEBT) formulary on the [SmithRx member portal](#). Also included is information about which drugs need prior authorization or have quantity limits.

## Preventative Medications

Certain preventative care prescription drugs mandated under Healthcare reform are covered at 100% with no participant cost-sharing when obtained in-network. An expanded list of 100% covered preventative medications is available to HDHP members.

## Customer Service

You can find additional information about your prescription drug plan at [www.SmithRx.com](http://www.SmithRx.com) and chat with a representative, contact SmithRx Customer Service by phone at 844.454.5201 or through email [connect@smithrx.com](mailto:connect@smithrx.com).

## Mail Order

Getting your medications through mail order is simple and convenient. You do not need a membership to utilize the mail order service or to pick up a prescription in person. SmithRx will assist with finding the best mail order option through COSTCO, Amazon Pharmacy, Walmart, or Mark Cuban Cost Plus.

**Step 1** – Register online at the chosen pharmacy. Select “Sign In/Register” to create an account. Enter all the required information.

**Step 2** – Fill your prescription. Request your new prescription online at the chosen pharmacy. Your provider can provide the prescription by calling or e-prescribing

**Step 3** – Obtain refills online at the mail order pharmacy or by calling or by enrolling in the auto refill program.

# SmithRx Pharmacy Partners

Accessing your prescriptions is easy with our **broad pharmacy network**, which gives you access to **retail**, **mail order**, and **specialty** pharmacies. You can always find the pharmacy with the best price by using the **Find My Meds** search tool in the Member Portal at [mysmithrx.com](https://mysmithrx.com).

## Retail Partners

We partner with over 65,000 pharmacies, including national and regional chains, grocery stores and local pharmacies. Here are just a few of the retail pharmacies in our network.



## Specialty Partners



To get started, visit [www.lumicera.com/costco-specialty-pharmacy](https://www.lumicera.com/costco-specialty-pharmacy) to enroll, or call **855-213-0070**. Providers can send prescriptions via e-scribe.

**Ordering:** The Costco Pharmacy Team helps you manage your refills. You can order refills through the Costco Member Portal or by phone.

**Shipping:** Shipping is free. Refrigerated medications are shipped the next day. Other medications are shipped within 2 days.



To enroll, call **888-777-5547**. Providers can send prescriptions via e-scribe.

**Ordering:** The Senderra Refill Specialists will call you when it's time to refill your medication. Orders need to be placed by phone.

**Shipping:** Standard shipping is free. Refrigerated medications are shipped overnight, except on Fridays. Other medications are sent with 2 day shipping.

## Mail Order Partners



**Get started at:** [rx.costco.com](https://rx.costco.com) to create a free Costco Pharmacy account. When placing refill requests, be sure to select the "mail order" delivery option at checkout.

Doctors can send prescriptions via e prescribe. You may also log into your Costco Pharmacy account and request your Rx be moved from the old pharmacy to Costco. For questions or assistance, please contact them at **1 (800) 607-6861**.



**Get started at:** [www.amazon.com/smithrx](https://www.amazon.com/smithrx). Doctors can send prescriptions via e prescribe, fax (512) 884-5981 or phone (855) 206-3605.



**Get Started at:** [www.walmart.com/cp/1042239](https://www.walmart.com/cp/1042239)

Doctors can send prescriptions via e prescribe, fax ( 800) 406-8976 or phone (800) 273-3455.



**Get started at:** [costplusdrugs.com/medications](https://costplusdrugs.com/medications), to see if your medication is available.

Doctors can send prescriptions via e prescribe.

## We are here to help!

Have questions or need assistance? Contact our Member Services Team. Live support is available **Monday through Friday, 8 am - 9 pm ET** and **Saturdays 11 am - 4 pm ET**.



### Chat

Chat live with a member service representative on our [website](#) or in the [member portal](#)



### Portal

Find plan info, ID cards and documents at [smithrx.com/portal](https://smithrx.com/portal)



### Email

Email our team at [help@smithrx.com](mailto:help@smithrx.com)



### Phone

Call us at [844-454-5201](tel:844-454-5201)

# PHARMACY BENEFITS FAQ FOR MEMBERS



## **What if a member has a general Rx question?**

Members should reach out to the SmithRx member support team. Online chat at [www.smithrx.com](http://www.smithrx.com), email [help@smithrx.com](mailto:help@smithrx.com), or call 844-454-5201.

## **What if a member has questions about a medication savings program?**

Members should reach out to the SmithRx Connect team. Online chat at [www.smithrx.com](http://www.smithrx.com), email [connect@smithrx.com](mailto:connect@smithrx.com), or call 844-385-7612.

## **What if a member gets a rejection at the pharmacy?**

Members should follow these steps:

1. Make sure they have brought their new or most updated ID card to the pharmacy.
2. Make sure the pharmacy is using the correct/updated insurance information.
3. Ask the pharmacy to explain the rejection.
4. If the member or pharmacy still has questions, call SmithRx at 844-454-5201 immediately, ideally while the member is still at the pharmacy.

## **What if a drug has a prior authorization (PA) requirement?**

Members can identify PA drugs using the formulary lookup tool on the member portal. Members should advise their doctor to send the PA electronically through Cover My Meds or fax completed PA forms to SmithRx. The PA form can be found at [SmithRx.com/Members](http://SmithRx.com/Members). Prescribers should call SmithRx at 844-512-3030 with any questions. If members have questions about the PA, they should reach out to the SmithRx member support team. Online chat at [www.smithrx.com](http://www.smithrx.com), email [help@smithrx.com](mailto:help@smithrx.com), or call 844-454-5201.

## **What if a drug has a step therapy (ST) requirement and the member wants to understand the process?**

Members can identify ST drugs using the formulary lookup tool on the member portal. Members should reach out to the SmithRx member support team. Online chat at [www.smithrx.com](http://www.smithrx.com), email [help@smithrx.com](mailto:help@smithrx.com), or call 844-454-5201.

## **What if a member wants to check the price of their medication at various pharmacies?**

Members can access the Find My Meds pricing tool by registering for the SmithRx member portal at [member.mysmithrx.com](http://member.mysmithrx.com). Within the tool, they can enter various drug details (ex: name, strength, quantity, and day supply) and find the price of the drug at pharmacies within a selected zip code or city.

## **What if a member's drug is considered specialty?**

Members can identify specialty drugs using the Formulary Lookup tool on the member portal. Members should advise their doctor to send the script to Costco Specialty or Senderra Rx.

### **Costco Specialty Pharmacy:**

Members can create an account on the Costco Pharmacy Member Portal ([Smithrx.com/Specialty](http://Smithrx.com/Specialty)). Once enrolled, members can log into the portal to request refills, manage their prescriptions and track orders. Prescribers can be directed to send prescriptions via e-scribe.

### **Senderra Rx:**

Patients can reach Senderra for enrollment assistance by calling 888-777-5547. Prescribers can visit <https://senderrax.com/prescribers> and fill out the appropriate forms for the appropriate department. Prescribers can send prescriptions via fax or e-scribe.

Once the member's prescriber has sent the script to the specialty pharmacy, the member should call the pharmacy to provide their insurance information and to schedule delivery.

### **What if a member wants to use mail order?**

Members can utilize our mail order partner pharmacies for convenience and savings. Our standard mail order partner is Amazon, but some members might end up using Walmart Home Delivery if they are on particular drugs, and that would be communicated to them by our Connect team.

#### **Costco Pharmacy:**

Patients can get started at [rx.costco.com](https://rx.costco.com) to create a free Costco Pharmacy account. When placing refill requests, they need to select the “mail order” delivery option at checkout. Doctors can send prescriptions via ecribe. Members may also log into their Costco Pharmacy account and request the Rx be moved from the old pharmacy to Costco.

#### **Amazon Pharmacy:**

Patients can register at [www.amazon.com/smithrx](https://www.amazon.com/smithrx) and reach the pharmacy at 855-745-5725. Prescribers can send prescriptions via electronic prescribing, fax or phone:

- Name/E-scribe: Amazon Pharmacy Home Delivery
- Amazon Pharmacy fax: 512-884-5981
- Amazon prescriber and pharmacy line: 855-206-3605

#### **Walmart Home Delivery:**

Patients can reach out for enrollment assistance by calling 800-273-3455, by email at [wmsrx@wal-mart.com](mailto:wmsrx@wal-mart.com), or register at <https://www.walmart.com/cp/1042239>.

Prescribers can send prescriptions via electronic prescribing, fax or phone:

- Walmart Pharmacy fax: 800 406-8976
- Walmart prescriber and pharmacy line: 800 273-3455

#### **Cost Plus Drugs:**

Cost Plus Drugs (CPD) pharmacy is another in-network mail order option. Members can check the Cost Plus website to see if generic medications are available there for a lower cost than what they are paying at retail. Additionally, the SmithRx Connect team may reach out to members about transitioning certain medications to CPD.

Patients can see whether their medications are available at <https://costplusdrugs.com/medications>, contact the pharmacy by completing the form at [costplusdrugs.com/contact/support](https://costplusdrugs.com/contact/support), or contact HealthDyne (NPI: 1295412286) at (888) 479-2000. Once your script has been sent by your prescriber to Mark Cuban Cost Plus Drug Company, members can register at [costplusdrugs.com](https://costplusdrugs.com).

### **What if a member is looking for more information on the cost, shipment, or delivery of their mail order or specialty medication?**

Members should reach out directly to the pharmacy that processed their medication.

### **What if a member receives an email, call or text from SmithRx?**

Members should respond as soon as possible to the email or the phone number from the voicemail or text they received. Members can also reach out via online chat at [www.smithrx.com](https://www.smithrx.com), email [help@smithrx.com](mailto:help@smithrx.com), or call 844-454-5201.





# DENTAL BENEFITS

Administered by Ameritas

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 the Ameritas dental benefit plan.

BASIC PLAN SERVICES	AMERITAS PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Calendar Year Deductible (Individual / Family)	\$75	\$150
Annual Benefit Maximum	\$2,000	
Preventive Dental Services (cleanings, exams, x-rays)	\$0, no deductible	80%, no deductible
Basic Dental Services (fillings, root canal therapy, oral surgery)	80% after deductible	50% after deductible
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50% after deductible	40% after deductible
Orthodontia Services (covered to age 19)	50%, no deductible \$2,000 lifetime maximum	Not covered

BUY-UP PLAN SERVICES	ANY PROVIDER
Calendar Year Deductible (Individual / Family)	\$75
Annual Benefit Maximum	\$2,000
Preventive Dental Services (cleanings, exams, x-rays)	\$0, no deductible
Basic Dental Services (fillings, root canal therapy, oral surgery)	80% after deductible
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50% after deductible
Orthodontia Services (covered to age 19)	50%, no deductible \$2,000 lifetime maximum

## Finding a Network Dentist

1. Go to [www.ameritas.com](http://www.ameritas.com) and click Find a Health Provider in the top menu.
2. Select Find a Network Dental Provider Online.
3. Enter your search criteria and choose Classic (PPO) network. If necessary, you can also narrow the results by name, distance, or specialty.
4. You may also call 800.659.2223 for assistance.





# DENTAL BENEFITS

## DENTAL BENEFIT DESCRIPTIONS

**TYPE 1 (PREVENTIVE):** Routine oral evaluations, x-rays, panoramic film, bitewing films, prophylaxis and fluoride, and palliative emergency treatment of pain.

**TYPE 2 (BASIC RESTORATIVE):** Basic fillings (amalgam and resin), extractions (including impacted wisdom teeth), endodontics (root canal, pulpal therapy), periodontics (treatment of gums including surgical periodontics), periodontal maintenance, oral surgery, and occlusal adjustment.

**TYPE 3 (MAJOR RESTORATIVE):** Space maintainers, inlays, onlays, crowns, dentures, bridges, tissue conditioning, and implants.

**CLASS D (ORTHODONTIA):**

Provided to dependent children under age 19.

**DENTAL FUSION BENEFIT:** Covered Members can use up to \$300 of their \$2,000 Dental Annual Maximum towards Vision Exams, Lenses, and Frames. Members will pay for the service out of pocket, request an itemized receipt, complete a Claim Form and submit to Ameritas for reimbursement up to \$300.

**NOTE:** This is a brief description only. Certain covered expenses may be subject to an elimination period. Please refer to your summary plan document for further information including rights, benefits, exclusions, and limitations. If a non-participating provider provides services, eligible expenses are limited to usual and customary amount as determined by Ameritas.

**QUESTIONS?** Please contact Ameritas Group Dental at 800-487-5553.



# VISION BENEFITS

Administered by VSP/EyeMed

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

<b>Deductibles</b>	<b>EyeMed/VSP Network + Affiliates</b> \$10 Exam \$10 Eye Glass Lenses or Frames*
<b>Annual Eye Exam</b>	Covered in full
<b>Lenses (per pair)</b>	
Single Vision	Covered in full
Bifocal	Covered in full
Trifocal	Covered in full
Lenticular	Covered in full
Progressive	See lens options
<b>Contacts</b>	
Fit & Follow Up Exams	Member cost up to \$60
Elective	Up to \$150
Medically Necessary	Covered in full
<b>Frames</b>	\$150**
<b>Frequencies (months)</b>	
Exams/Lens/Frame	12/12/12 Based on Plan Year

\*Deductible applies to a complete pair of glasses or to frames, whichever is selected. \*\*The Costco allowance will be the wholesale equivalent.

	<b>EyeMed/VSP Network + Affiliates (Other than Costco)</b>
<b>Progressive Lenses</b>	Up to provider's contracted fee for lined trifocal lenses. The patient is responsible for the difference between the base lens and the progressive lens charge.
<b>Std. Polycarbonate</b>	Covered in full for dependent children
<b>Solid Plastic Dye</b>	\$25 adults \$13
<b>Plastic Gradient Dye</b>	(except Pink I & II)
<b>Photochromatic Lenses (Glass &amp; Plastic)</b>	\$15 \$27-\$76
<b>Scratch Resistant Coating</b>	
<b>Anti-Reflective Coating</b>	\$15-\$29
<b>Ultraviolet Coating</b>	\$39-\$75 \$14



### Find a Network Provider

1. Register and log in to the member vision portal at [www.VSP.com](http://www.VSP.com)
2. Select Find A Doctor. You may search by location, office, or doctor.
3. Book your appointment!



### Find a Network Provider

1. Register and log in to the member vision portal at [www.EyeMed.com](http://www.EyeMed.com)
2. Select Find A Doctor. You may search by location, office, or doctor.
3. Book your appointment!





# SPENDING ACCOUNTS



## 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 a HSA, and that money is deducted from your 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.

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

Individual Coverage Contribution Maximum	\$4,400
Family Coverage Contribution Maximum	\$8,750



- ❖ Apache County offers a contribution of \$27.50 per pay period for individual coverage and up to \$55.00 per pay period for family coverage towards the employee's Health Savings Account (HSA). Over the span of 24 pay periods, this totals a maximum of \$660 for individual coverage and up to \$1,320 for family coverage. Contributions are typically available approximately 5-7 business days after each pay date.
- ❖ HSA accounts operate on a calendar-year basis. A participant can elect to contribute the maximum amount from July 1, 2026-December 31, 2026; however, to avoid tax issues, the individual must remain on the Health Savings Plan/HDHP through the full plan year following elections. Contribution maximum includes any Employer contribution.
- ❖ If you are age 55 and older, not enrolled in Medicare, you may contribute an \$1,000 Per Calendar Year.

## FLEXIBLE SPENDING ACCOUNT (FSA)

### Administered by Health Equity

You can save money on your healthcare and/or dependent day care expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

You must enroll in the FSA program within 30 days of your eligibility date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit [www.healthequity.com](http://www.healthequity.com) to access the online portal.

Healthcare Contribution Limit	\$3,400
Dependent Care Spending Limit	\$7,500 (\$3,750 if married filing separately)



# EMPLOYEE CONTRIBUTIONS

## 2026-27 Rates and Contributions

Vendor	Single Premium	Family Premium	Your Monthly Single Premium	Per Pay Period Single Premium	Your Monthly Family Premium	Per Pay Period Family Premium
Medical - PPO	\$818.48	\$1,940.28	\$78.00	\$39.00	\$256.00	\$128.00
Medical - HDHP	\$753.48	\$1,811.28	\$78.00	\$39.00	\$256.00	\$128.00
Dental	\$31.16	\$72.32	\$2.00	\$1.00	\$24.00	\$12.00
Dental Buy-up	\$34.44	\$80.60	\$6.00	\$3.00	\$44.00	\$22.00
Vision	\$8.96	\$20.82	\$0.00	\$0.00	\$10.00	\$5.00
Group Basic Life	\$4.41	\$6.91	\$0.00	\$0.00	\$0.00	\$0.00
Short-Term Disability	\$7.70	N/A	\$0.00	\$0.00	N/A	\$0.00





# LIFE INSURANCE BENEFITS

Administered by Ochs, A Securian Financial Company

Apache County 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. Employees also have an option to enroll in Voluntary Term Life.

## Basic Life Coverage - 100% employer paid & automatically enrolled

<b>Basic term life</b>	<b>\$50,000</b>	<ul style="list-style-type: none"> <li>✓ Includes a matching AD&amp;D benefit</li> <li>✓ Includes a Line of Duty benefit</li> </ul>
<b>Basic Dependent Package</b>	Spouse <b>\$10,000</b> and Child <b>\$10,000</b>	<ul style="list-style-type: none"> <li>✓ Includes your spouse and all eligible children live birth to age 26</li> <li>✓ Automatic benefit for employees enrolled in the Employer Sponsored Dependent Medical Plan; however, is optional for Dependents not covered. Employees not enrolled may elect this coverage.</li> </ul>

## Supplemental Life Coverage - 100% employee paid

<b>Supplemental term life</b>	Elect in <b>\$10,000</b> increments Maximum <b>\$750,000</b>	
<b>Spouse term life</b>	Elect in <b>\$5,000</b> increments Maximum <b>\$250,000</b>	<ul style="list-style-type: none"> <li>✓ Cannot exceed 100% of employee's basic &amp; supplemental coverage combined</li> <li>✓ Employee must be enrolled in supplemental life to elect spouse life</li> </ul>
<b>Child term life</b>	Elect <b>\$10,000</b> or <b>\$20,000</b>	<ul style="list-style-type: none"> <li>✓ Includes 1st newborn child benefit</li> <li>✓ Employee must be enrolled in supplemental life to elect child life</li> <li>✓ Cannot exceed 100% of employee's basic &amp; supplemental coverage combined</li> <li>✓ Available to elect without health questions each annual enrollment</li> </ul>

If your spouse or child is eligible for employee coverage, they cannot also be covered as a dependent. Only one employee may cover a dependent child. It is the employee's responsibility to notify their employer when dependents are no longer eligible.

## Monthly Cost

Employee or Spouse Supplemental Life	
Age	Rate per \$1,000
<25	\$0.06
25-29	\$0.06
30-34	\$0.07
35-39	\$0.08
40-44	\$0.13
45-49	\$0.21
50-54	\$0.35
55-59	\$0.55
60-64	\$0.86
65-69	\$1.55
70-74	\$2.78
75*	\$4.58

Child Life	
\$10,000	\$20,000
\$2.00	\$4.00

One premium covers all eligible children from live birth to age 26

### 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 in the PlanSource Portal.

\* Please see the full certificate for additional information, options, and restrictions.

\*Rates beyond age 75 are available upon request. Rates increase with age and all rates are subject to change.




## GROUP LIFE INSURANCE PROGRAM

# Guaranteed Issue & Evidence of Insurability (EOI)

### Life Insurance Coverage Available

#### No Health Questions!

There are certain times in which employees can enroll for coverage Guaranteed Issue. Guaranteed Issue means that coverage can be elected without answering health questions, otherwise known as Evidence of Insurability (EOI). Below is a breakdown of when coverage is Guaranteed Issue and when EOI and medical underwriting will be required.

 <p>Employee</p>	<p><b>NO HEALTH QUESTIONS</b></p> <ul style="list-style-type: none"> <li>✓ <b>Newly hired employees:</b> Up to <b>\$300,000</b> in <b>\$10,000</b> increments</li> <li>✓ <b>Qualifying Life Events:</b> Up to <b>\$300,000</b> in <b>\$10,000</b> increments</li> </ul>	<p><b>REQUIRES HEALTH QUESTIONS (EOI)</b></p> <ul style="list-style-type: none"> <li>✓ <b>Newly hired employees:</b> Elections over <b>\$300,000</b> up to <b>\$750,000</b></li> <li>✓ <b>Annual Enrollment:</b> <b>All elections and increases</b></li> </ul>
 <p>Spouse</p>	<p><b>NO HEALTH QUESTIONS</b></p> <ul style="list-style-type: none"> <li>✓ <b>Newly hired employees:</b> Up to <b>\$50,000</b> in <b>\$5,000</b> increments</li> <li>✓ <b>Qualifying Life Events:</b> Up to <b>\$50,000</b> in <b>\$5,000</b> increments</li> </ul>	<p><b>REQUIRES HEALTH QUESTIONS (EOI)</b></p> <ul style="list-style-type: none"> <li>✓ <b>Newly hired employees:</b> Elections over <b>\$50,000</b> up to <b>\$250,000</b></li> <li>✓ <b>Annual Enrollment:</b> <b>All elections and increases</b></li> </ul>
 <p>Child</p>	<p><b>NO HEALTH QUESTIONS</b></p> <ul style="list-style-type: none"> <li>✓ <b>Newly hired employees: All coverage</b></li> <li>✓ <b>Annual enrollment: All coverage</b></li> <li>✓ <b>Qualifying Life Events: All coverage</b></li> </ul>	

Questions? Contact Ochs. Email: [ochs@ochsinc.com](mailto:ochs@ochsinc.com) Phone: 800-392-7295



# DISABILITY INSURANCE

## DISABILITY INSURANCE

Apache County also provides short-term disability coverage through AZLGEBT. Long-Term Disability coverage is offered to employees contributing to the Arizona State Retirement System. A disability pension is offered to employees contributing to plans administered by the Public Safety Personnel Retirement System, including: PSPRS, CORP, AOC CORP and EORP.

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
<b>Short-term Disability</b>	You receive 60% of your weekly income. Benefits begin after 45 calendar days or the exhaustion of all accrued paid leave whichever is longer and may continue for up to 135 calendar days.	Apache County
<b>Long-term Disability/Disability Pension</b>	Please see the applicable retirement website for details on your Long-Term Disability coverage or Disability Pension Coverages.	Apache County and Employee (Shared Contribution)





## EMPLOYEE ASSISTANCE PROGRAM

**JORGENSEN** brooks  
group  
Employee Assistance Programs

**Confidential, free help** for personal, family and work problems.

Your Employee Assistance Program [EAP] works closely with you to help correct situations before they interfere with your home or work life. We do this with high quality counseling [JBG Clinical Care] and work-life services [JBG Personal Care].

### What types of problems are covered by JBG Clinical Care?

Confidential assessment and brief counseling for:

- Anxiety
- Stress
- Minor Depression
- Grief and Loss
- Substance Abuse
- Workplace Issues
- Gambling
- Child and Family Conflicts

### How do I contact JBG Clinical Care and what should I expect?

- Call Jorgensen Brooks Group [JBG] toll free, **888-520-5400** for prompt, live response.
- Local counseling appointments typically, Monday to Friday, 8:00am through 4:30pm.
- Virtual and telephone appointments are offered at client choice.
- **Crisis services are available 27 hours/7 days.**

### How many counseling sessions are available?

- You and your family members have up-to-six [6] free sessions per problem, per person, per year. Sessions for marital / relationship and family / child situations are authorized for the group involved; separate sessions may be authorized for individuals upon clinical review.
- Adult children receive services until the age of 26.

### What if I need services beyond JBG Clinical Care?

- JBG Clinical Care will first refer you to network providers in your medical plan. We can also direct you to self-help groups or other available community resources.

### FIRST RESPONDER CARE

JBG is a leading provider of dedicated resources to First Responders, with crisis and counseling staff, providers, and other focused services.

*Expanded services are available through many Departments; confirm with your group.*



You and your family have **free, unlimited use of JBG Personal Care**; the services are **available 24 hours / 7 days by telephone, internet chat, or website.**

Call - 24 hours / 7 days  
Toll Free: 888-520-5400

### JBG Personal Care Website

- ⇒ [www.jorgensenbrooks.com](http://www.jorgensenbrooks.com)
- ⇒ Home page, under “Our Services” Click JBG Personal Care”,
- ⇒ Find and click on “Click here to access your JBG Personal Care” in the new window type your Company Login, “AZLGEBT”.

### Live Chat

- ⇒ Follow instructions to JBG Personal Care
- ⇒ Home page upper left, click on LIVE CONNECT
- ⇒ Complete brief inquiry form to connect to Chat Now

### Mobile App – EAP / Assist

- ⇒ Download from Google Play [android] or App Store [IOS]
- ⇒ Register on the app
- ⇒ Enter Employer number “AZLGEBT” and password “JBG” [ not case sensitive]

*JBG Personal Care* is another important benefit of your Employee Assistance Program. With this free, confidential service, professional consultants help you solve non-clinical problems for which you may not have experience or resources. Without the support of *JBG Personal Care*, life’s pressures can become over-whelming.

Examples of key [not all] *JBG Personal Care* services are:

- **Legal:** Will preparation; estate issues; landlord disputes; separation and divorce; civil and criminal matters. Services include an up-to-30-minute free consultation [in-person or by telephone] with a local attorney, and a 25% discount on network attorney fees. Employee disputes with employers are not covered.
- **Financial:** Budgeting; personal financial management; negotiating credit card debt. Financial planning is a regulated service and not included.
- **ID theft recovery:** Assistance with prompt notification of creditors and other financial providers; guidance on managing a return to control of your identity.
- **Child and Elder care:** Locating appropriate providers and specialty resources for infants, children and older citizens.
- **Education:** Resources for primary and private, non-profit and profit, trade and higher education.
- **Housing:** Resources for temporary and permanent, self-paying or subsidized options.
- **Savings Center:** Discounts on thousands of personal, home and business goods without a membership fee.
- **Medical advice:** Website information provided through the *Mayo Clinic*.

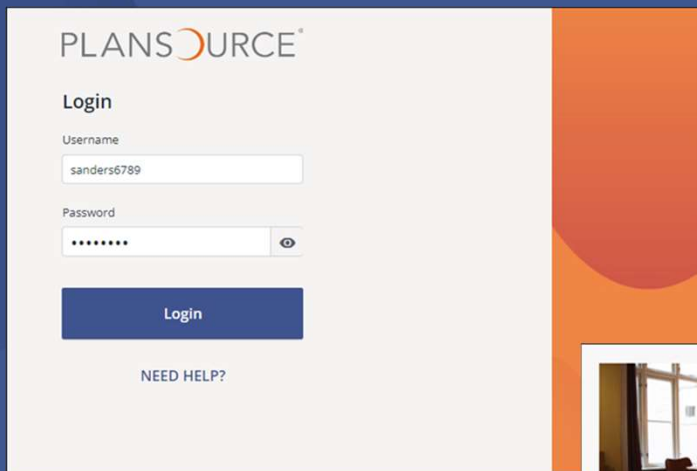
**Call – 24 hours / 7 days**  
**Crisis Line and Immediate Support**  
**Toll Free: 888-520-5400**  
**Always Confidential**

# PLANSOURCE

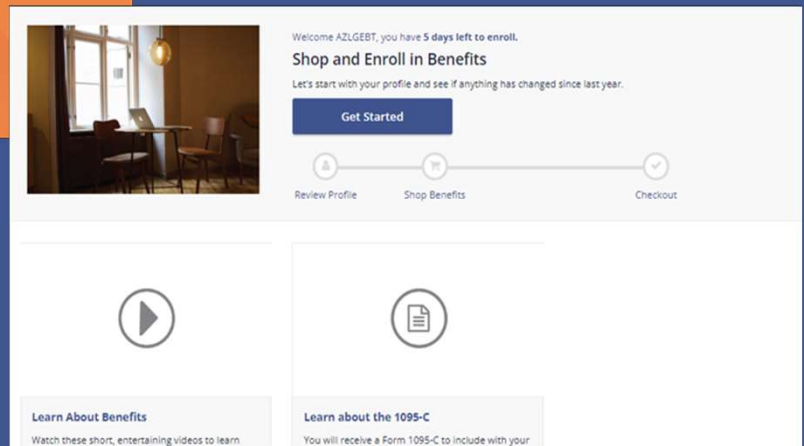
## POWERFULLY SIMPLE BENEFITS MANAGEMENT

Shop, enroll and learn about your benefits with PlanSource via your laptop or mobile device.

Login at <https://benefits.plansource.com/> and click on “Get Started” to begin.



- Shop, Enroll, and Compare Benefits – Decision IQ provides Best Match Recommendation
- Cost Calculations for Employee and Employee + Family tiers outlined within each Benefit



**USERNAME:** For example, employee Sarah Anderson (social 123-45-6789) would have the following username: sanders6789.

**PASSWORD:** If this is your first login, you will be prompted to reset your password. Forgot your password? Click “Need Help?”

**Remember to finalize your selections by 5:00 p.m. Arizona Time on Thursday, May 21, 2026**



## WELLBEING PROGRAM AND PREVENTIVE SCREENINGS

Administered by Gallagher Benefit Services

The comprehensive Wellness Program is available to all employees, spouses, and dependents 18+ enrolled in the medical plan. The Wellness Program focuses on early detection, healthy habit tracking, and health education. Below is a brief overview of major program offering.

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

**Health Risk Assessment:** Provides a snapshot of risk factors to development of chronic conditions, such as cardiovascular disease and diabetes.

Biometrics include height, weight, BMI, blood pressure, and waist circumference. Venipuncture blood draw includes Total Cholesterol, HDL, LDL, Triglycerides, Glucose, Kidney and Liver Function, Calcium, Electrolytes, PSA, and more!

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

**Healthy Heart Blood Draw:** Checks blood pressure, blood glucose, total cholesterol, and LDL & HDL cholesterol levels.

**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.

Bone Density test. Spirometry test.

Retinopathy Screening: Takes a quick snapshot of the inner eye to detect early signs of health problems based on the appearance of blood vessels and other structures.

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

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

**Prostate Exams:** Routine screenings will be brought onsite every other year for men 40 years and older.

Preventive screenings and services brought onsite through the AZLGEBT Wellness Program are covered at 100% for Employees and dependents covered on the AZLGEBT Medical Benefit Plan.

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



## WELLBEING PROGRAM

Administered by Gallagher Benefit Services

### Digbi treats the **Biology**



100+ published papers, 85 granted US patents.



Genetic, Gut-Microbiome, and CGM Testing



Identify the root cause of members conditions



Personalized clinical & lifestyle care

### Truly personalized health intelligence

**COACHING**

Unlimited Access to Coaching Calls, Group Coaching, Async Materials

**MEAL PLANNER**

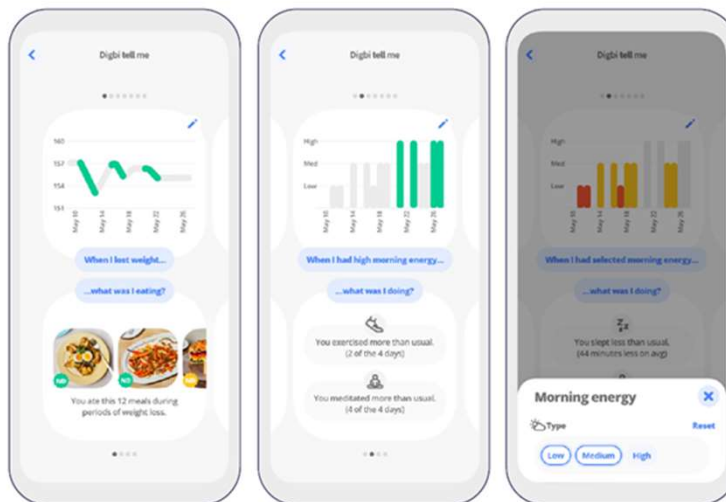
20,000+ rated ingredients and 5,000+ recipes personalized to your biology

**WEIGHT & COMORBIDITY TRACKING**

In app weight, digestive, mental health, and exercise and meals tracking

**DIGBI COMMUNITY**

Connects members with group coaching calls, recipe books, continued learning, etc



# 2026-27 WELLBEING CALENDAR



## 2026-27 Annual Wellness Calendar

JULY	AUGUST	SEPTEMBER	OCTOBER
Cardiac & Organ Screenings 	Healthy Heart Blood Draw 	Flu Vaccinations Mammography Screening	Flu Vaccinations Mammography Screening
NOVEMBER	DECEMBER	JANUARY	FEBRUARY
		Health Risk Assessment 	Health Risk Assessment 
MARCH	APRIL	MAY	JUNE
Health Risk Assessment 	Skin Cancer Screenings 	Skin Cancer Screenings 	Cardiac & Organ Screenings 

Preventive screenings and services are subject to change. Watch for emails and flyers with more details. Preventive screenings and services brought onsite through the AZLGEBT Wellness Program are covered 100% for eligible AZLGEBT Medical Benefit Plan Members. Questions? Contact your local Wellness Coordinator or [Kingman.GBS.ArizonaGovEERBenefitTrust@ajg.com](mailto:Kingman.GBS.ArizonaGovEERBenefitTrust@ajg.com).

# VOLUNTARY BENEFITS

While you can't predict life's unexpected events, you can plan for them by choosing benefits that help protect what's important to you.

**If you are currently enrolled or enroll during this annual open enrollment, please add your beneficiaries in the PlanSource portal.**

## ACCIDENT

Administered by Aetna

The Accident plan provides cash payments directly to you to help cover out-of-pocket costs, such as deductibles or coinsurance. The full schedule of benefits payable for accidental injuries include initial/follow-up treatment, ambulance trips, medical imaging, surgeries, concussion, dislocations and fractures, hospital stays, AD&D, and health screening benefits. It is important to note this benefit is for off the job accidents only. Some benefits are payable once per covered accident, while others are once per plan year. See Benefit Summary for detailed information and schedule of benefits and exclusions.

## CRITICAL ILLNESS

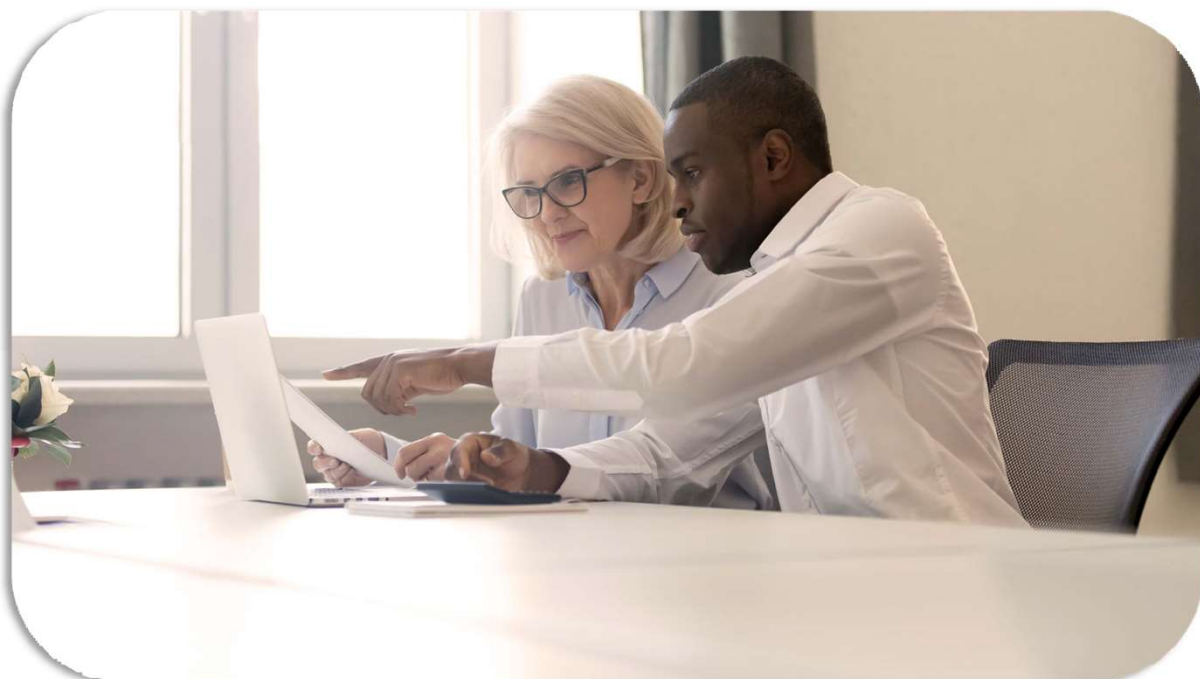
Administered by Aetna

Critical illness insurance provides a lump-sum payment for an insured person diagnosed with any of the following critical illnesses while insurance is in effect for the insured person, after any applicable waiting period and subject to any pre-existing condition limitation: Cancer, Heart Attack, Stroke, Organ Transplant, Kidney Failure, and more. See Benefit Summary for detailed information and schedule of benefits and exclusions.

## HOSPITAL INDEMNITY

Administered by Aetna

Hospital indemnity coverage eases the financial impact of an employee's hospitalization by providing a lump sum payment to help cover the costs associated with a hospital stay. Hospital indemnity coverage can be used to supplement medical insurance to help handle additional out-of-pocket costs that add up after a hospital stay. This can include copayments, coinsurance, deductibles, and incidental hospital expenses or other expenses such as transportation and lodging needs. See Benefit Summary for detailed information and schedule of benefits and exclusions.





# Cover your bases

## Aetna<sup>®</sup> Accident Plan

### **Be prepared for the unexpected**

Accidents are just that — accidents. You can't plan for them. But, you can protect yourself financially as much as possible.

### **An Aetna Accident Plan can help**

The Aetna Accident Plan pays benefits when you get treatment for an accidental injury. The plan pays for a long list of covered minor and more serious injuries. You can use the benefits to help pay out-of-pocket medical costs or personal expenses.

### **How is this different from a major medical plan?**

Medical plans help pay providers for services and treatment. But, they don't cover the unexpected costs that might come with an accidental injury.

The Aetna Accident Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

**The Aetna Accident Plan is underwritten by Aetna Life Insurance Company (Aetna).**

Aetna.com  
57.03.501.1 (02/21)

### **How can you use the cash benefits?**

It's completely up to you. You can use the money any way you want. It can help you pay your:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or anything else you choose.

### **Easy to use**

Online tools make it easy to manage your plan on our app or member portal. You can file a claim in about 90 seconds or less if you or a family member experience a covered injury or treatment. And, benefits get paid directly to you by check or direct deposit.





# By your side

## Aetna<sup>®</sup> Critical Illness Plan

### **Be prepared for what happens next**

Critical illness coverage can keep you focused on your health when it matters most. These plans can help ease some financial worries during a difficult time.

### **An Aetna Critical Illness Plan can help**

The Aetna Critical Illness Plan pays you lump-sum cash benefits when a doctor diagnoses you with a covered serious illness or condition, like heart attack, stroke, cancer and more.\* You can use the money to help pay out-of-pocket medical costs or personal expenses.

### **How is this different from a major medical plan?**

Medical plans help pay providers for services and treatment. But, they don't cover the unexpected costs that can come with a serious illness.

The Aetna Critical Illness Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

\*Refer to your plan documents to see all covered illnesses under the plan.

**The Aetna Critical Illness Plan is underwritten by Aetna Life Insurance Company (Aetna).**

[Aetna.com](https://www.aetna.com)

57.03.502.1 (02/21)

### **How can you use the cash benefits?**

It's completely up to you. You can use the money any way you want, like:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or for anything else you choose.

### **Easy to use**

You can file a claim in about 90 seconds or less if you or a family member experience a covered diagnosis or condition. And, benefits get paid directly to you by check or direct deposit.





# Less stress

## Aetna® Hospital Indemnity Plan

### Be prepared for what lies ahead

Maybe you're expecting to have a hospital stay — or maybe not. Either way, you can plan ahead to give yourself an extra financial cushion.

### The Aetna Hospital Indemnity Plan can help

The plan pays you a lump-sum cash benefit for a covered hospital admission and daily stays—even when you deliver a baby. You can use the money to help pay out-of-pocket medical costs or personal expenses. The choice is yours.

### How is this different from a major medical plan?

Medical plans help pay providers for services and treatment. But, they don't cover the unexpected costs that might come with a stay in the hospital.

The Aetna Hospital Indemnity Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

### How can you use the cash benefits?

It's completely up to you. You can use the money any way you want. It can help pay:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or for anything else you choose.

### Easy to use

Online tools make it easy to manage your plan on our app or member portal. You can file a claim in about 90 seconds or less if you or a family member experience a covered hospital stay. And, benefits get paid directly to you by check or direct deposit.

**The Aetna Hospital Indemnity Plan is underwritten by Aetna Life Insurance Company (Aetna).**

[Aetna.com](https://www.aetna.com)

57.03.503.1 (02/21)



# Supplemental health benefits, right at your fingertips.

With the new My Aetna Supplemental app and portal, managing your benefits is a breeze. Whether you're on your laptop or your mobile device, you can take charge of your supplemental coverage.

## See how much easier it can be to manage your health benefits.

Either online or via the app, you can:



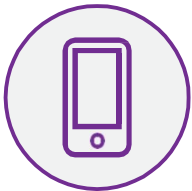
View coverage and benefits.



Submit and track claims.



Sign up for direct deposit  
of claims.



Submit documents —  
just take a picture with  
your phone and upload.





Access Aetna  
discount programs.



View and download other  
materials or forms from the  
document library.

## Ready to discover the My Aetna Supplemental app and portal?

Ways to sign on:

- **Download the My Aetna Supplemental app**  
- **Log on to [MyAetnaSupplemental.com](https://www.MyAetnaSupplemental.com)** — the Aetna Supplemental Health member portal

**Policies are insured by Aetna Life Insurance Company (Aetna). For more information about Aetna plans, go to [Aetna.com](https://www.Aetna.com).**

Apple, the Apple logo and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc.

Google Play and the Google Play logo are trademarks of Google LLC.

[MyAetnaSupplemental.com](https://www.MyAetnaSupplemental.com)

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57.03.487.1 (10/19)



# Aetna Simplified Claims Experience™

## Aetna Accident, Critical Illness and Hospital Indemnity Plans

Filing claims for supplemental health benefits couldn't be easier

### Get cash benefits fast

You can get cash benefits when you or a covered family member experience an accident, diagnosis of a serious illness or hospital stay.

### It's easy to submit claims on the app or member portal

Here's how it works:

Download the **My Aetna Supplemental** app to your smart device. You can also **scan the QR code** to visit [Myaetnasupplemental.com](https://myaetnasupplemental.com).



Register on the site if you haven't already. (You'll need your Aetna supplemental health Member ID or social security number.) Since you're a Meritain medical member, you can also access the member portal through [Aetna.com](https://Aetna.com).

1. Click on "Report New Claim."
2. Follow the steps and answer the questions.
3. Review your claim for accuracy and submit.

You or your covered family member have a covered event.



You submit a supplemental health claim on the app or member portal.



Our system matches the supplemental health claim to your Meritain medical claim to get information to help process your claim.\*



We send your benefit to you by check or direct deposit.



\*If you're not a Meritain medical member, you'll need to upload your medical documentation. Accepted documents include an itemized bill, or Uniform Medical Billing Form 2004 (UB04).

## Get cash benefits for taking care of your health

The Aetna Accident Plan pays a **\$50** cash benefit, and the Aetna Critical Illness and Hospital Indemnity Plans include an annual **\$50** benefit for covered preventive health screening tests. This benefit is available once per covered member per year, per plan. Follow the same steps to file a claim and reap the cash rewards.

### Other ways to file claims

You can also print and mail claims forms to Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or Fax to **1-859-455-8650**. Claims forms are available for download from the bottom of the screen when you access the member portal or call Aetna Member Services.

### Have questions? Need help?

View your benefits summary on our secure member website, available 24/7. Or you can call Aetna Member Services Monday through Friday, 8 AM. to 6 PM at **1-800-607-3366 (TTY: 711)**.



# Benefits With Gallagher Marketplace

Giving you year-round access to additional benefits that could save you money.

Gallagher Marketplace is your gateway for discovering and accessing unique benefits that best fit your lifestyle. Our program offers significant savings on things you are already buying—like home and auto, pre-paid legal services, identity theft protection, pet insurance, renters insurance, boat or RV insurance and employee discount perks. Gallagher Marketplace also offers access to individual medical, dental and vision coverage as well as Medicare supplemental programs.

With a centralized hub, you can explore an array of benefit options, available not only to Gallagher clients but also to their friends and families.

Discover what benefits your organization offers through Gallagher Marketplace.

### The Value

- Whether full-time, part-time or contract workers, all employees and their families are eligible
- Benefit access and potential savings through bundling with the ability to choose from multiple carriers
- Potential costs savings compared to shopping on your own
- Licensed insurance advisors to help find the policy that meets your needs

### The Convenience

- Enroll any time of the year, not just during open enrollment
- Simple sign-up with payment options
- Easily compare rates from multiple carriers
- Schedule a callback from licensed insurance advisors for a time that's most convenient
- All programs are portable so you can keep the coverage no matter where life takes you

### How It Works

1

[Visit Gallagher Marketplace](#) to see your available benefits.

2

Select a product to view more details.

3

Click on the partner link to learn more, get a free no obligation quote or apply for coverage.

Scan the QR code to learn more





## CONTACT INFORMATION

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

BENEFIT	VENDOR	PHONE	WEBSITE OR EMAIL
Medical Claims Administrator	AmeriBen	1.877.635.2912	<a href="http://www.MyAmeriBen.com">www.MyAmeriBen.com</a>
Precertification and Case Management	American Health Group	1.800.847.7605	<a href="mailto:info@amhealthgroup.com">info@amhealthgroup.com</a>
Medical Network	Blue Cross Blue Shield of Arizona	1.877.635.2912	<a href="http://www.azblue.com">www.azblue.com</a>
Telemedicine	AZBlue Telehealth		<a href="http://www.AZBlueTelehealth.com">www.AZBlueTelehealth.com</a>
Prescription	SmithRx	1.844.454.5201	<a href="http://www.SmithRx.com">www.SmithRx.com</a>
Dental	Ameritas	1.800.487.5553	<a href="http://www.ameritas.com">www.ameritas.com</a>
Vision	VSP	1.800.877.7195	<a href="http://www.vsp.com">www.vsp.com</a>
Vision	EyeMed	1.866.939.3633	<a href="http://www.eyemed.com">www.eyemed.com</a>
Health Savings Account	Health Equity	1.866.346.5800	<a href="http://www.healthequity.com">www.healthequity.com</a>
Flexible Spending Account	Health Equity	1.866.346.5800	<a href="http://www.healthequity.com">www.healthequity.com</a>
Life and AD&D	Ochs, Inc./Securian	1.800.392.7295	<a href="http://www.ochsinc.com">www.ochsinc.com</a>
Employee Assistance Program	Jorgensen Brooks Group	1.888.520.5400	<a href="http://www.jorgensenbrooks.com">www.jorgensenbrooks.com</a>
Patient Advocacy Program	American Health Group	1.800.847.7605	<a href="mailto:info@amhealthgroup.com">info@amhealthgroup.com</a>
Voluntary Benefits	Aetna	1.800.607.3366	<a href="http://www.MyAetnaSupplemental.com">www.MyAetnaSupplemental.com</a>
State Retirement Systems	AZ State Retirement System	1.800.621.3778	<a href="http://www.azasrs.gov">www.azasrs.gov</a>
State Retirement Systems	AZ Public Safety Personnel Retirement System	1.602.255.5575	<a href="http://www.psprs.com">www.psprs.com</a>



## LEGAL NOTICES

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### Patient Protections Disclosure

The Arizona Local Government Employee Benefit Trust Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit [www.azblue.com](http://www.azblue.com).

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from AmeriBen or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the BCBSAZ at [www.azblue.com](http://www.azblue.com).

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### 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. Therefore, the following deductibles and coinsurance apply:

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

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### 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).

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### HIPAA Notice of Privacy Practices Reminder

#### Protecting Your Health Information Privacy Rights

Your employer is committed to the privacy of your health information. The administrators of the Arizona Local Government Employee Benefit Trust (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting your local Human Resources department.

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# **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](http://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](http://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](http://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 –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162, Press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a> Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> <a href="http://www.in.gov/fssa/df/">http://www.in.gov/fssa/df/</a> 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: <a href="#">Iowa Medicaid   Health &amp; Human Services</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="#">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="#">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a> HIPP Phone: 1-888-346-9562	Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> 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: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a> KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a> Phone: 1-877-524-4718 Kentucky Medicaid Website: <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a>	Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a> Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-977-6740 TTY: Maine relay 711	Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a> Phone: 1-800-862-4840 TTY: 711 Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a>
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a> Phone: 1-800-657-3672	Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084 Email: <a href="mailto:HSHIPPPProgram@mt.gov">HSHIPPPProgram@mt.gov</a>	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

<p align="center"><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>  Medicaid Phone: 1-800-992-0900</p>	<p align="center"><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a>  Phone: 603-271-5218  Toll free number for the HIPP program: 1-800-852-3345, ext. 15218  Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a></p>
<p align="center"><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Phone: 1-800-356-1561  CHIP Premium Assistance Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p align="center"><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>
<p align="center"><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>  Phone: 919-855-4100</p>	<p align="center"><b>NORTH DAKOTA – Medicaid</b></p> <p>Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a>  Phone: 1-844-854-4825</p>
<p align="center"><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>	<p align="center"><b>OREGON – Medicaid and CHIP</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>  Phone: 1-800-699-9075</p>
<p align="center"><b>PENNSYLVANIA – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a>  Phone: 1-800-692-7462  CHIP Website: <a href="#">Children's Health Insurance Program (CHIP) (pa.gov)</a>  CHIP Phone: 1-800-986-KIDS (5437)</p>	<p align="center"><b>RHODE ISLAND – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>  Phone: 1-855-697-4347, or  401-462-0311 (Direct Rlte Share Line)</p>
<p align="center"><b>SOUTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>	<p align="center"><b>SOUTH DAKOTA - Medicaid</b></p> <p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>  Phone: 1-888-828-0059</p>
<p align="center"><b>TEXAS – Medicaid</b></p> <p>Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a>  Phone: 1-800-440-0493</p>	<p align="center"><b>UTAH – Medicaid and CHIP</b></p> <p>Utah's Premium Partnership for Health Insurance (UPP) Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a>  Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a>  Phone: 1-888-222-2542  Adult Expansion Website: <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a>  Utah Medicaid Buyout Program Website: <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a>  CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a></p>
<p align="center"><b>VERMONT– Medicaid</b></p> <p>Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a>  Phone: 1-800-250-8427</p>	<p align="center"><b>VIRGINIA – Medicaid and CHIP</b></p> <p>Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a>  <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a>  Medicaid/CHIP Phone: 1-800-432-5924</p>
<p align="center"><b>WASHINGTON – Medicaid</b></p> <p>Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a>  Phone: 1-800-562-3022</p>	<p align="center"><b>WEST VIRGINIA – Medicaid and CHIP</b></p> <p>Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a>  <a href="http://mywvhipp.com/">http://mywvhipp.com/</a>  Medicaid Phone: 304-558-1700  CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p align="center"><b>WISCONSIN – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>  Phone: 1-800-362-3002</p>	<p align="center"><b>WYOMING – Medicaid</b></p> <p>Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a>  Phone: 1-800-251-1269</p>

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](http://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](http://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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 3/31/2026)

# HIPAA SPECIAL Enrollment Rights

## Arizona Local Government Employee Benefit Trust Medical Plan **Notice of Your HIPAA Special Enrollment Rights**

Our records show that you are eligible to participate in the Arizona Local Government Employee Benefit Trust Medical Plan . To actually 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 31 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 31 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 your local Human Resources department.

### **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.

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

## Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Arizona Local Government Employee Benefit Trust Medical Plan 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 offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Arizona Local Government Employee Benefit Trust Medical Plan has determined that the prescription drug coverage offered by the medical plan is, 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 Arizona Local Government Employee Benefit Trust Medical Plan coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Arizona Local Government Employee Benefit Trust Medical Plan coverage, be aware that you and your dependents will be able to get this coverage back.

### 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 the Arizona Local Government Employee Benefit Trust and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

### For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov).
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

**Date: July 1, 2026**

**Name of Entity/Sender: Arizona Local Government Employee Benefit Trust**

**Contact—Position/Office: Gallagher Benefit Services, Trust Administrator**

**Office Address: 8800 East Raintree Drive, Suite 250**

**Scottsdale, AZ 85260**

**Phone Number: 928-753-4700**

# **COBRA GENERAL NOTICE**

## **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.

## **How is COBRA continuation coverage provided?**

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

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

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

### ***Disability extension of 18-month period of COBRA continuation coverage***

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

**Second qualifying event extension of 18-month period of continuation coverage**

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

**Are there other coverage options besides COBRA Continuation Coverage?**

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

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).

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period<sup>1</sup> to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

### If you have questions

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

### Keep your Plan informed of address changes

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

### Plan contact information

Arizona Local Government Employee Benefit Trust  
c/o Gallagher Benefit Services, Trust Administrator  
8800 E Raintree Dr., Suite 250 Scottsdale AZ 85260

<sup>1</sup> <https://www.medicare.gov/basics/get-started-with-medicare/sign-up>

### Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Summary does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

This document is an outline of the coverage provided by the Arizona Local Government Employee Benefit Trust Medical Plan. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The Summary Plan Description and Plan Document must be read for those details.

Remember, no action is required if you are not modifying your present benefit elections. **Exception:** A yearly enrollment and contribution election *is required* for participants in the Flexible Spending Account.

Please contact your local Human Resources department for questions.

# **MARKETPLACE NOTICE**

## **Health Insurance Marketplace Coverage Options and Your Health Coverage**

### **PART A: General Information**

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

#### **What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

#### **Can I Save Money on my Health Insurance Premiums in the Marketplace?**

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

#### **Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%<sup>1</sup> of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.<sup>1 2</sup>

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

#### **When Can I Enroll in Health Insurance Coverage through the Marketplace?**

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2026 and July 31, 2027, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2026, and July 31, 2027, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

### **What about Alternatives to Marketplace Health Insurance Coverage?**

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

### **How Can I Get More Information?**

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your local human resources department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

## **PART B: Information About Health Coverage Offered by Your Employer**

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are permanent employees that work 20 or more hours a week.

Some employees. Eligible employees are:

- With respect to dependents: <<Check applicable box and insert plan information in that section.>>

We do offer coverage. Eligible dependents are: spouse, children under age 26, or disabled dependents of any age that became disabled prior to age 26.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

\*\* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.



*This benefit summary prepared by*



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