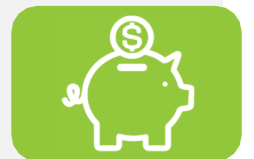


2025-26 BENEFITS GUIDE



Apache County

July 1, 2025 – June 30, 2026





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.

TABLE OF CONTENTS

Benefits Overview	2
Medical Benefits	6
How Your Plans Work	13
Pharmacy Benefits	14
Dental Benefits	16
Vision Benefits	18
Spending Accounts	19
Employee Contributions for Benefits	20
Life Insurance Benefits	21
Disability Insurance	23
Employee Assistance Program	24
PlanSource Information	26
Wellbeing Program	28
Voluntary Benefits	32
Contact Information	37
Legal Notices	38

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


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 44 for more details.



The cost of healthcare continues to be significant. To help control healthcare costs, utilize Teladoc 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 28, 2025 – Ends Friday, May 23, 2025 at 11:59 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 28 to Friday, May 23, 2025** in the PlanSource Portal. If you do not make changes, your current elections will stay in effect for the 2025-26 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 2025-26 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. If you need an additional medical/prescription card, register or log in 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 to submit a request or call Ameritas Customer Care Center at 1-800-487-5553.



BENEFIT CHANGES EFFECTIVE JULY 01, 2025

ADMINISTRATIVE

Add Patient Advocacy Program
Remove Precertification for Hospice
Medical Re-card for all Employees due to adding PHCS Network

MEDICAL – PPO

Add Coverage through the PHCS Network for 49 Other States
Add Teladoc Behavioral Mental Health at a \$0 Copay
Increase Urgent Care Copay from \$45 to \$50
Increase Emergency Room from \$100 Copay, then 80% after Deductible to: \$150 Copay, then 80% after Deductible

MEDICAL – HDHP

Add PHCS Network for 49 other states
Add Teladoc Behavioral Mental Health Subject to Deductible
Add Expanded Preventive Medications at a \$0 Member Cost Share
Discontinue Teladoc & Telemedicine \$0 Member Cost Share effective July 01, 2025. Member Cost Share will apply per Schedule or Benefits






WELLNESS

Replace Livongo Program with Digbi Health Program -Cost share Waiver for Members with Diabetes Diagnosis



CHOOSING THE RIGHT CARE

Quick reference guide for medical treatment options:

	Hours	Your Relative Cost *	Description
AmeriBen 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. 877-635-2912
American Health Group 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. 800-847-7605
Jorgenson Brooks Group Mental Health	24 hours, 7 days a week	No additional cost to you	The Jorgenson Brooks Group provides precertification for Behavioral Health and Substance Abuse 888-520-5400
Doctor's Office 	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.
Teladoc 	24 hours, 7 days a week	Usually lower out-of-pocket costs to you than urgent care	24/7 access to a provider via phone and 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 1-800-TELADOC www.teladoc.com
Retail Health Clinic 	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.
Urgent Care Provider	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.
Emergency Room (ER) 	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
Plan Year Deductible		
Per Person	\$3,750	\$7,000
Family Maximum	\$7,500	\$14,000
Out-of-pocket Maximum		
Per Person	\$3,750	\$14,000
Family Maximum	\$7,500	\$28,000
	(Includes deductible)	(Includes deductible)
Inpatient Hospital	100% after deductible	50% after deductible
Outpatient Facility	100% after deductible	50% after deductible
Office Visits	100% after deductible	50% after deductible
Urgent Care Facility	100% after deductible	50% after deductible
Preventive Services (services as required by law as well as routine physicals and all AZLGEBT onsite screenings)	100% no deductible	Not Covered
Chiropractic Care (limited to 26 visits and \$40 eligible charge per visit)	100% after deductible	50% after deductible
X-ray/Lab (in office)	100% after deductible	50% after deductible
X-ray/Lab (outpatient facility)	100% after deductible	50% after deductible
Maternity	100% after deductible	50% after deductible
Emergency Room	100% after deductible (waived if admitted)	100% after deductible (waived if admitted)
Behavioral/Mental Health and Substance Use Disorders – Inpatient (includes residential treatment)	100% after deductible	50% after deductible
Behavioral/Mental Health and Substance Use Disorders – Outpatient (includes partial hospitalization)	100% after deductible	50% after deductible
Prescription Drugs (The deductible is waived for smoking cessation drugs, prescribed preventive medications, and contraceptives as required by federal law)	100% after deductible Available only through Navitus participating pharmacies and Navitus Specialty Rx program	Not Covered
Telemedicine/Teladoc	100% after deductible	
Employee Assistance Program (EAP)	6 visits per issue	



MEDICAL BENEFITS

Administered by AmeriBen and BCBSAZ

PPO PLAN OUTLINE OF BENEFITS		
MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
Plan Year Deductible Per Person	\$500	\$1,500
Out-of-pocket Maximum Per Person Family Maximum	\$5,500 \$14,300 (Includes deductible)	Unlimited Unlimited (Includes deductible)
Inpatient Hospital	80% after deductible	50% after deductible
Outpatient Facility	80% after deductible	50% after deductible
Office Visits Primary Care Specialist	\$30 co-pay \$45 co-pay	50% after deductible 50% after deductible
Urgent Care Facility	\$50 co-pay	50% after deductible
Preventive Services (services as required by law as well as routine physicals and all AZLGEBT onsite screenings)	100% no deductible	Not Covered
Chiropractic Care (limited to 26 visits and \$40 eligible charge per visit)	\$30 co-pay	50% after deductible
X-ray/Lab (in office) Primary Care Specialist	\$30 co-pay \$45 co-pay	50% after deductible 50% after deductible
X-ray (outpatient facility)	\$30 co-pay	50% after deductible
Lab (outpatient facility)	\$30 co-pay if under \$500 80% after deductible	50% after deductible
Maternity	80% after deductible	50% after deductible
Emergency Room	\$150 copay then 80% after deductible (waived if admitted)	\$100 copay then 80% after deductible (waived if admitted)
Behavioral/Mental Health and Substance Use Disorders – Inpatient (includes residential treatment)	80% after deductible	50% after deductible
Behavioral/Mental Health and Substance Use Disorders – Outpatient (includes partial hospitalization)	80% after deductible	50% after deductible
Telemedicine/Teladoc		\$0
Employee Assistance Program (EAP)		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 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 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 "CHS".
3. Choose your location and search



OUTSIDE OF ARIZONA MEDICAL NETWORK

Members may also use the PCHS network outside of AZ. Go to providersearch.multiplan.com, select "Find a Provider," then select PHCS network (Logo on back of card). Now search for the provider, specialty or facility type, and zip code.

HMN???



MEDICAL CLAIMS ADMINISTRATION

Administered by AmeriBen

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

To register on MyAmeriBen mobile app:

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



Claims status

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



Digital ID card

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



Online support

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



Benefit information

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



Document upload

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



Telemedicine

Administered by Teladoc

Avoid expensive emergency room visits by using Teladoc. 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 \$65 for HDHP members or \$0 for PPO members.

Discover the convenience, comfort, and savings of Teladoc

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, Teladoc 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

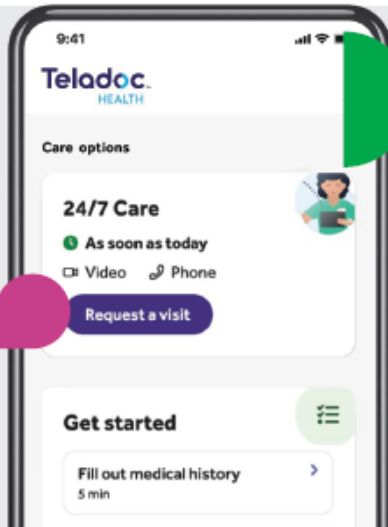
You can get the benefits of an in-person counseling session online. Schedule an appointment with a board-certified counselor or psychologist to get help for depression and anxiety, as well as stress caused by grief, divorce, parenting challenges, job loss, and other major life changes.

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	\$65 (100% after deductible)
Counseling	\$0 copay	\$95 (100% after deductible)
Psychiatry	\$0 copay	\$105-\$235 (100% after deductible)

General Medical: What to know about this benefit



Did you know 60% of patients have to wait 2 weeks to see their primary physician and only 10% are able to get in to see their regular doctor the same day they need care?¹

Our Teladoc Health benefit gives you access to compassionate care from U.S. board certified clinicians, anytime, anywhere. Providers are available in all 50 states and you can meet with them 24/7 by phone or video.

The average Emergency Room care costs 10 times more than an urgent care visit for the same diagnosis.²

Teladoc Health can help you skip the trip to the ER or urgent care for non-emergency problems, avoid long wait times and save money since you can see a clinician within minutes by phone or video. Teladoc Health is here to listen, answer your questions and help you feel better faster.

Virtual Behavioral Health Care

Coming Soon: July 1, 2025

Access to Mental Health Care

In addition to your Teladoc Health 24/7 Care services, you will soon have access to Mental Health support. You'll have access to confidential therapy 7 days a week for conditions like depression, anxiety, stress, marital or family issues and much more by phone or video.



On average,
90% of people
who used our mental health solution
say it helped them **feel better.***

The benefits of using Teladoc Health Mental Health

- ✓ Choose the therapist who best fits your needs
- ✓ Speak with an expert from wherever you are most comfortable
- ✓ Schedule an appointment when it's convenient for you
- ✓ Confidential treatment for as little or as long as you need



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

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

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
Monthly Cost for Coverage (Individual / Family)	\$58 / \$236	\$58 / \$236
Deductible (Individual / Family)	\$3,750 / \$7,500	\$500
Out-of-pocket Maximum (Individual / Family)	\$3,750 / \$7,500	\$5,500 / \$14,300
Spending Account Options	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
What medical plan can I choose?	HDHP	PPO plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)
When can I use the funds?	Funds are available as you contribute to the account	All of the funds you elect for the year are available on the first payday after July 1
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	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
How do I pay for eligible expenses?	With your Health Equity debit card (You can also submit claims for reimbursement online at www.healthequity.com)	With your Health Equity debit card (You can also submit claims for reimbursement online at www.healthequity.com)
How much can I contribute each year?	\$4,300 for individual coverage or \$8,550 for family coverage	You can contribute up to \$3,300 annually.
Can my employer contribute?	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.
Can I change my contributions throughout the year?	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 Navitus

PHARMACY	HDHP		PPO PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
			Preferred Network	
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 Navitus. Log into your Navitus account to review the list. www.Navitus.com .		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	
			Non-preferred Pharmacy (CVS and Walgreens) copays are higher.	

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 (NAEBT) formulary on the Navitus 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.navitus.com or contact Navitus Customer Service at 855.673.6504. Both resources are available 24 hours a day, 7 days a week.



Mail Order

Getting your medications through Costco Pharmacy mail order is simple and convenient. You do not need to be a Costco member to utilize the mail order service or to pick up a prescription in person.

Step 1 – Register online at www.costco.com/home-delivery. Select “Sign In/Register” to create an account. Enter all the required information.

Step 2 – Fill your prescription. Request your new prescription online at www.costco.com/home-delivery. Your provider can provide the prescription by calling 800.607.6861 or e-prescribing it to Costco.

Step 3 – Obtain refills online at www.costco.com/home-delivery, or by calling 800.607.6861 or by enrolling in the auto refill program.





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 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.

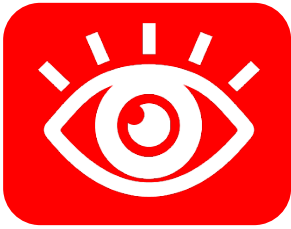
CLASS D (ORTHODONTIA):

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.

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

	EyeMed/VSP Network + Affiliates (Other than Costco)
Progressive Lenses	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.
Std. Polycarbonate	Covered in full for dependent children
Solid Plastic Dye	\$25 adults \$13
Plastic Gradient Dye	(except Pink I & II)
Photochromatic Lenses (Glass & Plastic)	\$15 \$27-\$76
Scratch Resistant Coating	
Anti-Reflective Coating	\$15-\$29
Ultraviolet Coating	\$39-\$75 \$14



Find a Network Provider

1. Register and log in to the member vision portal at 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
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	\$4,300
Family Coverage Contribution Maximum	\$8,550



- ❖ 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, 2025-December 31, 2025; 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 to access the online portal.

Healthcare Contribution Limit	\$3,300
Dependent Care Spending Limit	\$5,000



EMPLOYEE CONTRIBUTIONS

2025-26 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	\$758.02	\$1,790.68	\$58.00	\$29.00	\$236.00	\$118.00
Medical - HDHP	\$698.22	\$1671.46	\$58.00	\$29.00	\$236.00	\$118.00
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	\$44.41	\$6.91	\$0.00	\$0.00	\$0.00	\$0.00
Short-Term Disability	\$6.04	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

Basic term life	\$50,000	<ul style="list-style-type: none"> ✓ Includes a matching AD&D benefit ✓ Includes a Line of Duty benefit
Basic Dependent Package	Spouse \$10,000 and Child \$10,000	<ul style="list-style-type: none"> ✓ Includes your spouse and all eligible children live birth to age 26 ✓ 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.

Supplemental Life Coverage - 100% employee paid

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

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

Questions? Contact Ochs. Email: 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; including PSPRS, CORP, AOC CORP, and EORP.

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
Short-term Disability	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
Long-term Disability/Disability Pension	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.*

PRE-CERTIFICATION / MANAGEMENT INPATIENT & OUTPATIENT SERVICE

All admissions for mental health and substance abuse treatment inpatient and outpatient [including testing] must be pre-certified [approved] in advance. The facility or provider must call JBG (888-520-5400) to report the specifics of the care, after which JBG can pre-certify the admission.



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
- ⇒ 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*.

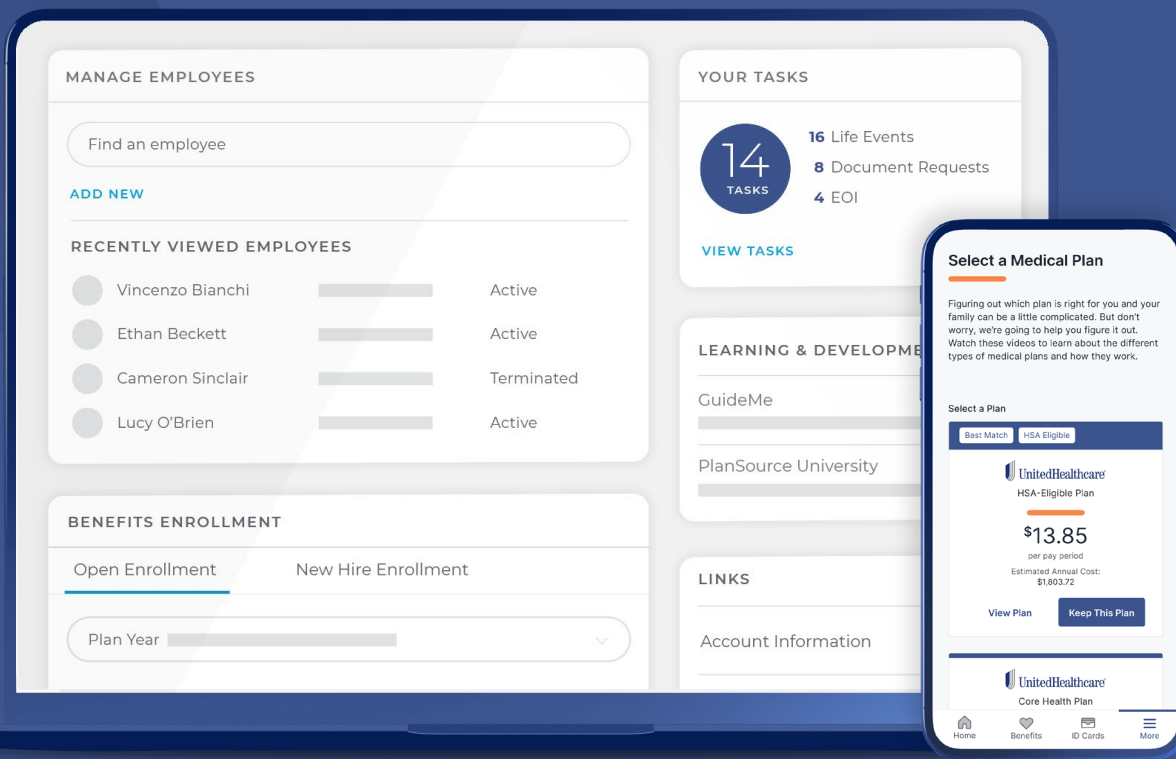
Call – 24 hours / 7 days
Crisis Line and Immediate Support
Toll Free: 888-520-5400
Always Confidential

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.



AZLGEBT:

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

Remember to finalize your selections by 11:59 p.m. Arizona Time on Friday, May 23, 2025

PLANSOURCE

ENROLLING FOR THE FIRST TIME

The first time you log in, you will be prompted to change your password. Please follow the instructions below.

The image displays two screenshots from the PLANSOURCE website. The left screenshot shows the login page with the PLANSOURCE logo at the top. Below the logo is the heading "Login". There are two input fields: "Username" with the text "sanders6789" and "Password" with a masked password "*****" and an eye icon. A blue "Login" button is positioned below the fields, and a "NEED HELP?" link is at the bottom. The right screenshot shows the enrollment page. It features a welcome message: "Welcome AZLGEBT, you have 5 days left to enroll." followed by the heading "Shop and Enroll in Benefits" and the instruction "Let's start with your profile and see if anything has changed since last year." A blue "Get Started" button is prominent. Below this is a progress bar with three steps: "Review Profile" (with a person icon), "Shop Benefits" (with a shopping cart icon), and "Checkout" (with a checkmark icon). At the bottom, there are two video thumbnails: "Learn About Benefits" with a play button icon and "Learn about the 1095-C" with a document icon. The text under the second video reads "You will receive a Form 1095-C to include with your".

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

PASSWORD: You will be prompted to reset your password upon login.

Remember to finalize your selections by 11:59 p.m. Arizona Time on Friday, May 23, 2025



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

Livongo Update / Digbi Health Implementation

Livongo, the current Diabetes management program, will be terminated 7/1/25. It will be replaced by Digbi, a much more comprehensive and holistic approach to care. Digbi uses Precision Biology to treat over 400 different conditions, including diabetes, digestive health and obesity. Through a combination of gut tests, genetic tests and continuous glucose monitors, Digbi physicians create a personalized approach to care that is based on the user's unique biology. This intentional and specific approach to care is incredibly impactful as it is based on *your* specific needs. Digbi will launch July 1, 2025. Please stay tuned for more information!

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

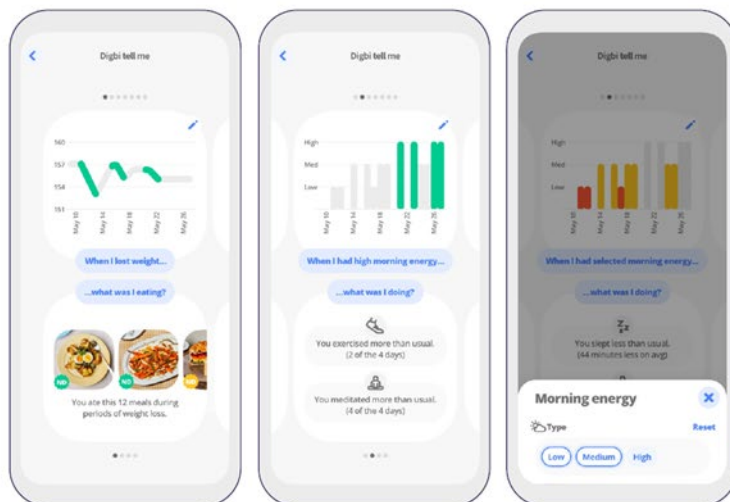
20,000+ rated ingredients and 5,000+ recipes personalized to your biology

WEIGHT & COMORBIDITY TRACKING

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








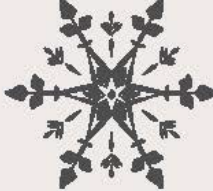


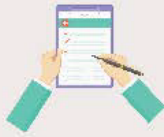



DIGBI COMMUNITY

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



2025-26 Annual Wellness Calendar

2025-26 Annual Wellness Calendar

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

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.

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.

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[®] 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[®] 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.aetna.com/MyAetnaSupplemental)** — 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.aetna.com/MyAetnaSupplemental.com)

©2019 Aetna Inc.
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.

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)**.



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	www.MyAmeriBen.com
Medical Review	American Health Group	1.800.847.7605	info@amhealthgroup.com
Medical Network	Blue Cross Blue Shield of Arizona	1.877.635.2912	www.azblue.com
Mental Health/Substance Abuse Precertification	Jorgensen Brooks Group	1.888.520.5400	www.jorgensenbrooks.com
Telemedicine	Teladoc	1.800.835.2362	www.Teladoc.com
Prescription	Navitus	1.480.798.6268	www.navitus.com
Dental	Ameritas	1.800.487.5553	www.ameritas.com
Vision	VSP	1.800.877.7195	www.vsp.com
Vision	EyeMed	1.866.939.3633	www.eyemed.com
Health Savings Account	Health Equity	1.866.346.5800	www.healthequity.com
Flexible Spending Account	Health Equity	1.866.346.5800	www.healthequity.com
Life and AD&D	Ochs, Inc./Securian	1.800.392.7295	www.ochsinc.com
Employee Assistance Program	Jorgensen Brooks Group	1.888.520.5400	www.jorgensenbrooks.com
Voluntary Benefits	Aetna	1.800.607.3366	www.MyAetnaSupplemental.com
State Retirement Systems	AZ State Retirement System	1.800.621.3778	www.azasrs.gov
State Retirement Systems	AZ Public Safety Personnel Retirement System	1.602.255.5575	www.psprs.com



LEGAL NOTICES

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.

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.

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.

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).

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.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/df/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

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

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

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

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

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, 2025

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.

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 period¹ to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

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

¹ <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.



This benefit summary prepared by



Insurance | Risk Management | Consulting