

YCT Freedom of Choice **Flexible Benefit Plan**



YCT
Yavapai Combined Trust

Annual Benefits Enrollment Guide For Plan Year July 1, 2016 – June 30, 2017

For Employees of the City of Prescott, Town of Chino Valley,
Yavapai College, and Yavapai County

YCT is comprised of four entities: the Town of Chino Valley, the City of Prescott, Yavapai County, and Yavapai College. Our benefits plan is self-insured, with claims paid by an independent claims administrator. The Trustees meet once each quarter to review and vote on any action items. The Trust has appointed a committee, called the HR Advisory Group, which meets monthly to discuss problems, solutions, and make recommendations to the Trustees at their quarterly meeting.

It's Time For Open Enrollment For Your 2016-2017 Benefits

This Benefits Enrollment Guide is designed to provide an overview of the benefit options that are available to you and your eligible dependents through the Yavapai Combined Trust (YCT). Read through this Guide to become familiar with the YCT benefit plans, then for more detailed information, review your YCT Plan Document at www.yctrust.net

INTRODUCTION TO YOUR BENEFITS ENROLLMENT GUIDE

Things To Remember As You Use This Benefits Enrollment Guide

It is very important that you review this Guide so you can fully understand the benefit plans offered to you by YCT. This is your opportunity to select the coverage appropriate for you and your eligible dependents.

During Open Enrollment you can make changes to your benefits for the coming plan year. You can change your plan, or add/drop coverage or dependents. Any changes you elect will be for the 12-month period that runs from July 1, 2016 through June 30, 2017.

During your initial benefits enrollment, newly benefits-eligible employees must enroll within 31 days of the date of hire or becoming benefits-eligible. You may take the following actions:

- Elect or waive medical, dental and/or participating employer vision plan(s) for yourself and qualified dependents.
- Elect or waive Voluntary Life Insurance for yourself and qualified dependents.
- Elect or decline to participate in the Flexible Spending Account (FSA) plans.

- **It's Important To Understand Your Benefits**
- Your HR Department and the Plan's Claims Administrators stand ready to answer your questions about your coverage and the options available to you and your family.
- It is very important that you carefully review the 2016 YCT Plan Document available on line at www.yctrust.net and understand your responsibility in the decisions you make regarding in-network versus out-of-network care.
- **Out-of-network care**, such as an out-of-state facility or Mayo Clinic, will most likely result in a higher cost to you. Even if your in-network physician refers you to an out-of-network provider, claims will be reimbursed at out-of-network rates that could result in balance billing to you. **In-network providers offer your greatest value.**
- You can check to see if a provider is in- or out-of-network by going online to www.yctrust.net. Additionally, if you receive care that is determined to be medically unnecessary, it will not be covered by the Plan. Remember, your health care is ultimately your responsibility, and we want you to get the care you need at the lowest cost to you.

**Information at your fingertips!
Visit www.yctrust.net for access to
information on Summit Administration Services, Inc.,
the prescription drug program, FSAs,
precertification, and more.**



ENROLLING FOR BENEFITS



The Freedom Of Choice Plan

The Trust offers you a choice of different benefit options to better meet your personal needs.

The Freedom of Choice plan offers:

- Medical (Premier, High Deductible Health Plan with a Health Savings Account, and Basic Plus)
- Dental (Comprehensive and Preventative)
- Vision (from participating employers)
- Flexible Spending Accounts (FSAs) for health care and dependent care

How To Enroll

1. Read this Guide carefully.
2. Review your current benefits, how they are meeting your needs, and what, if any, changes you should make during Open Enrollment. Careful planning is the key to getting the most from your benefits.
3. Decide which benefit choices are best for you and your family.
4. Remove any dependents who are no longer eligible for continued coverage such as a divorced spouse or your child age 26 or older (unless disabled).
5. Complete, sign and return your Benefits Elections Form to your HR Department by the enrollment deadline.

What Happens If You Do Not Enroll?

Open Enrollment is the one time each year when you can make a change to your benefit elections without a "Qualifying Event". **You will also need to fill out an FSA form each year if you wish to participate in the Flexible Spending Accounts.**

As a newly benefits-eligible employee, you must make your initial enrollment selections within 31 days of your date of eligibility. **If you fail to enroll within the 31-day enrollment period, you waive your right to enroll in these plans until the next Open Enrollment or until you have a Special Enrollment Event.**

Flexible Spending Accounts

If you want to participate in a Flexible Spending Account (FSA), you must enroll each year. To participate in an FSA for the 2016-2017 plan year, you must complete an FSA enrollment form indicating your contributions for the 12-month period (see page 12 for more information).

Changing Your Coverage During The Year

Due to Federal regulations, once you enroll in the Freedom of Choice Plan, you will not be able to add or change coverage for yourself or your dependents until the next Open Enrollment period unless you have a qualifying mid-year change as defined by the IRS. See page 15 for details about allowable mid-year changes to your elections.



Q: Can I pick one medical plan for myself and another for my dependents?

A: No. You and your eligible dependents must all be enrolled in the same medical plan.

Q: Can I enroll in a medical plan for myself, and elect family coverage for the dental and vision plans if offered or vice versa?

A: Yes. This is the beauty of the YCT Freedom of Choice Flexible Benefit plan. You select the coverage that fits your needs.

Q: Who is Health Equity?

A: Health Equity is the Health Savings Account administrator for the High Deductible Health Plan medical option. Their contact information is on the back page of this Guide.



The Yavapai Combined Trust group medical, dental and vision policy number is YCT001.

HOW THE FREEDOM OF CHOICE PLAN WORKS

Who's Eligible?

You are eligible if you are an employee of a participating employer of the YCT and are:

- Regularly scheduled to work "full-time" as defined by your employer's personnel policy; or
- An elected member of a Governing Body, while in office, as provided through the participating employer's written policy.

If you elect medical coverage for yourself, your eligible dependents are also eligible for coverage on the latter of: (1) the day you become eligible for coverage, (2) the day they become an eligible dependent either by birth, adoption or placement for adoption or (3) the first of the month following the day they become an eligible dependent by marriage. You must complete and submit the appropriate form within 31 days of your dependent becoming eligible for coverage or at Open Enrollment.

Eligible dependents include your:

- Lawful spouse; and
- Dependent child(ren), as defined in the YCT plan document.

Under the YCT Plan, there are different age limits for benefits eligibility for dependent children, as noted below:

- Medical plan benefits can be continued for a child up to the end of the month in which the child turns age 26.
- Dental plan and/or Vision plan benefits can be continued for a child up to the end of the month in which the child turns age 23.

Questions about eligibility should be directed to your HR Department.

NOTE: If you and your spouse both work for an employer participating in the YCT, you may each be covered as employees. You may also decide that instead of each employee electing coverage as an employee, one of you may elect coverage as the employee and the other as the dependent spouse. Also, dependent children may be covered by one spouse and not by both. See your YCT Plan Document for the definitions of "spouse" and "dependent children."

Your benefit elections can only be changed during Open Enrollment — unless you have a qualifying mid-year change — so plan your elections carefully. Make sure to complete and submit your Benefits Elections Form before the deadline. If you want to participate in a Flexible Spending Account, you must enroll each year.



When Coverage Begins

The plan year is July 1 to June 30 each year. The benefits you elect now will go into effect on July 1, 2016, or if you are a new benefits-eligible employee, your coverage will become effective as of the first day of the month after you have been employed full-time for 30 days.

Paying For Your Benefits

Each year, your employer contributes a certain amount to apply toward the cost of benefits. You can use these contributions to help pay for medical, dental or vision coverage for you and your dependents. If the total cost of your benefit elections is more than your employer's contributions, you will have to make additional contributions via payroll deductions each pay period.

The Pre-Tax Advantage

Your benefit premiums are deducted on a pre-tax basis, saving you federal, state and Social Security taxes by reducing your taxable income.

By having the pre-tax option, you cannot change coverage during the year unless you have a mid-year change in status as per IRS guidelines, which restricts the type of changes you can make to your coverage during a plan year. See page 15 for details regarding mid-year changes to your elections.

Member ID/Prescription Drug Cards

Your Member ID/Prescription Drug card shows network claims administration and verification information. The other side shows prescription benefit information. If you are enrolling for the first time, contact your HR Department if you do not receive your card within 14 days of the date you enroll for coverage.

Employees who do not have medical coverage, but have dental and/or vision coverage, will receive an ID card with claims administration and verification information from their HR Department.



The Freedom of Choice plan offers you a choice of three medical plan options. Understanding the differences between the medical plan options can help you decide which plan is best for you and your dependents. For more detailed information, refer to your YCT Plan Document.

Medical Coverage Options

You may waive coverage or choose from the following options:

- Premier Plan;
- Basic Plus Plan; or
- High Deductible Health Plan.

Premier Plan

The Premier Plan is a Preferred Provider Organization (PPO) which allows you to use any qualified provider you choose without a referral. You must meet the annual deductible including copays for some services, then most in-network expenses are paid at 80%. You also have the option to visit out-of-network providers. You may have to pay additional money out of your pocket if you use out-of-network providers.

Basic Plus Plan

The Basic Plus Plan option provides protection against major medical expenses, providing 60% coverage of medical costs. The Basic Plus Plan does not provide out-of-network medical coverage except in a true emergency. To receive benefits, you must use a BCBSAZ preferred in-network provider. To find an in-network provider, go online to www.yctrust.net.

High Deductible Health Plan (HDHP)

The HDHP allows you the greatest control over your out-of-pocket health care expenses. Once you meet your annual deductible, most in-network expenses are covered at 100% for the remainder of the benefit year.

When you enroll in the HDHP, you can also contribute to a Health Savings Account (HSA) which allows you to use pre-tax contributions to pay for eligible health care expenses. Any money in your HSA will automatically roll over to future plan years, even if you are no longer enrolled in the HDHP. Page 5 explains more about this HDHP option.

Annual Out-of-Pocket Limit

Under the Premier Plan and the Basic Plus Plan, the out-of-pocket limit is the most you pay in coinsurance toward covered expenses during the plan year. After reaching the out-of-pocket limit, generally the plan pays 100% for eligible expenses up to the Annual Benefit Limit.

For the HDHP, the amount you pay to satisfy your plan year deductible is included in the out-of-pocket limit.

For all medical plan options, if you use an out-of-network provider you may be responsible for the difference between the Plan's allowed amount and the provider's billed charges. These charges do not apply to your out-of-pocket limit. When you seek out-of-network care, be sure to discuss your possible share of the costs with your provider before you receive care.

Coverage Levels

Under the medical plan, you may elect coverage for:

- Employee Only; or
- Employee + Family.



Terms To Know

Deductible: The amount of eligible expenses you must pay each year before the plan begins to pay benefits.

Copay: The amount you pay to the provider each time you receive a certain service.

Coinsurance: The portion of eligible medical expenses for which you have financial responsibility in excess of the plan's deductible. For example, the Premier Plan pays 80% in-network, then you pay 20%; the Basic Plus Plan pays 60% in-network, then you pay 40% (after you have met your deductible).

Preferred provider: A health care provider (including doctors, hospitals, labs and urgent care facilities) that is a member of the Blue Cross Blue Shield of Arizona Preferred Provider Organization (BCBSAZ PPO) network and who have agreed to charge lower, pre-negotiated discount fees for eligible services.

YCT Plan Document: A detailed document that describes your medical, dental, vision and short-term disability benefits for participants in the Yavapai Combined Trust.

How The HDHP Works

The HDHP allows you to choose any qualified provider without a referral. Your benefits will be the greatest when you choose in-network providers. You must meet the annual deductible (which is a high deductible) before the plan pays any qualified expenses. Like the Premier Plan, you also have the option to visit out-of-network providers. However, the HDHP pays only 50% of allowable expenses for an out-of-network provider and you will be responsible for the remainder plus any additional costs over the allowed amount.

Special Features of the Plan

If an HDHP sounds right for your situation, there are a few significant differences between this plan and the traditional PPO plans that you should consider. You must first pay the \$2,500 individual or \$5,000 family in-or out-of-network deductible before the Plan starts paying benefits. You can use the money in your HSA to pay for qualified health care expenses once you meet your annual deductible. After your deductible is met, the Plan's coinsurance pays 100% for in-network services and 50% for out-of-network services until you reach the out-of-pocket limit for the plan year.

A Health Savings Account (HSA) is available only when you enroll in an HDHP

When you elect coverage under the HDHP option, you will be able to establish an HSA. You will receive more information from Health Equity (the HSA Administrator) on how to make HSA contributions, and how you can access the money in your HSA to pay for eligible health care expenses. In many instances, paying for eligible expenses is as easy as using your HSA debit card. However, keep in mind that the amount available to you can never exceed the amount in your HSA at the time of withdrawal.

You will need to complete and return an additional enrollment form in order to establish your account. This account can help you pay for eligible health care expenses for you and your family, along with expenses not covered by the plan, such as your deductible. The account is managed by Health Equity and acts like a checking account with a debit card. The funds are available to you once they are deposited into your account, and you can use your HSA debit card to make qualifying purchases. If there is not enough money in your account to cover an eligible expense, you can be reimbursed for the amount once the funds have been deposited.

For 2016–2017, if you are an active employee, you may contribute up to \$3,350 for individual coverage, and \$6,750 for family coverage on a pre-tax basis. If you are 55 or older, you can also make an additional \$1,000 “catch-up” contribution. All money deposited into your account will earn interest just like a savings account, but on a tax-free basis. You will still be able to use the money that remains in your account to pay for qualified expenses even after you stop participating in an HDHP, so you can use your account to save for health care expenses you may experience in the future.

Paying Expenses from Your HSA

When you enroll in an HDHP, you pay expenses out of your own pocket or out of your HSA until you meet the annual deductible. Then the plan starts to pay benefits. There are exceptions for certain preventive medications and medical services that are not subject to the deductible.

If you pay expenses through your HSA, you have already used pre-tax dollars, so you cannot deduct those expenses on your individual tax return. You are responsible for determining whether or not an expense is eligible to be paid from your account. If you use the money in your HSA for non-eligible expenses, that distribution will be taxed, generally with a 20% penalty.



Each year you wish to contribute to your HSA, you will need to complete and return a new election form, indicating your desired HSA contribution for that year.

Eligible Health Care Expenses

An HSA can help you pay for certain health care expenses that are not otherwise covered by the plan, including your annual deductible. In general, eligible health care expenses include any non-reimbursable medical, dental, or vision expense that can otherwise be deducted on your individual tax return if you itemize deductions. Eligible deductions are described in IRS Publication 502.

Some examples of reimbursable medical care can include:

- copayments and coinsurance amounts;
- prescription drugs;
- vision services including exams, eye surgery, glasses, and contact lenses;
- dental treatments;
- smoking cessation programs;
- weight-loss programs (if prescribed by your physician for a specific disease);
- chiropractic care;
- hearing aids;
- additional amounts you pay when you do not use an in-network provider (for example, amounts over the plan's allowed amount);
- long-term care; and
- Medicare premiums (including Part A, Part B, Part D, and Medicare managed care) or premiums for COBRA coverage.

To see a complete list of allowable expenses, visit the IRS website at www.irs.gov and review Publication 502. If you still have questions, contact a Member Services specialist by calling Health Equity at **1-866-346-5800** anytime, day or night.

How To Enroll In A Health Savings Account (HSA)

If you are electing an HDHP medical option for the first time, you will need to complete an additional enrollment form in order to establish your HSA and choose the amount you wish to contribute to your account. You must be HSA-eligible in order to establish an HSA. Check with your employer's benefit office or attend an open enrollment meeting for more information.

Anyone can contribute to your HSA; however, only your employee contributions will qualify for pre-tax savings. Once you have established your account, you can use your HSA debit card to pay for qualified expenses for you and any dependents that you claim on your tax return. Remember, you can only withdraw funds after they are deposited into your account.

Five Reasons To Enroll In An HSA

1. Your employer contributes funds to your account.
2. Easy-to-use online access to check your account balance, pay bills, or get reimbursements.
3. Live Member Services specialists available 24/7. Get the help you need when you need it with personalized assistance from a specialist anytime, day or night. You can rely on a live Member Services specialist when you need help negotiating payments schedules with a provider, finding the average costs for treatments and prescriptions within your zip code area, or simply learning safe, effective ways to save on health care costs.
4. Safe, tax-free growth for your money. Your cash deposits are FDIC-insured. In addition, you'll be earning tax-free interest. Even if you don't use all of the money in your account, your account balance will continue to grow each year, and you won't have to pay taxes on any interest earned.
5. No "use-it-or-lose-it" restriction. The money in your account can be used in years when you have greater-than-expected health care expenses. Or, at retirement, you can use the money to help pay for retiree health expenses. For more information, call the HSA administrator, Health Equity, at **1-866-346-5800**, or visit **www.healthequity.com**.



Special Note: In order to open an HSA and make tax-free contributions to your account, you must be "HSA eligible." IRS guidelines define an HSA-eligible individual as a person who:

- is covered under an HDHP,
- has no other health coverage (except as permitted by the IRS),
- is not enrolled in Medicare, Medicaid or Tricare during the plan year, and
- cannot be claimed as a dependent on someone else's tax return.



Prescription Drug Coverage

All three medical plan options offer outpatient prescription drug benefits through the OptumRx network. Outpatient prescription drug coverage is automatic when you enroll in a medical plan. You will not be able to opt out of prescription drug benefits coverage.

To find an in-network pharmacy, or to review the current formulary go online to **www.yctrust.net** and click on prescription coverage.

From the YCT website, you can access the OptumRx prescription drug member website, **OptumRx.com**. All prescriptions must be filled at a network pharmacy or through the OptumRx Home Delivery service.

The OptumRx Formulary is a list of covered medications that will allow you to maximize the value of your prescription benefit. You can make the most of your pharmacy benefit plan and control your prescription medication costs by using this formulary. Be sure to share it with your doctor to select cost-effective medications that are clinically appropriate to treat your condition or maintain your health.

The formulary is updated quarterly. Medications that no longer offer the best therapeutic value for the plan are deleted and a letter is sent to any member affected by the change. To review the current formulary or get up-to-date information on your pharmacy benefit, go online to **www.yctrust.net** and click on prescription coverage or go to **OptumRx.com** and sign in.

If you have not logged into the OptumRx website before, click on the "Register" link to get started. Enter your name, date of birth and an email address then create a password to open your personal account.

The OptumRx Mobile App provides on-the-go access to your personalized health information when you need it. Visit **m.optumrx.com** or **OptumRx.com** to download the OptumRx Mobile App to:

- Show your doctor exactly what drugs you are taking and view your prescription claims history.
- Find network retail pharmacies by ZIP Code or GPS location.
- Create and update automated text message reminders about taking and ordering your medications.
- Check the status of your mail service orders.

OptumRx Mail Service Pharmacy is a convenient and less expensive service available for plan participants who require maintenance medications for ongoing health conditions or who are going to be in an area with no participating retail pharmacy for an extended period of time. For more information call **1-800-797-9791** (TTY: 711).

Clinical Prior Authorization is needed for certain medications before they can be filled, even with a valid prescription. The authorization process may be initiated by you, your local pharmacy, or your physician by calling OptumRx at **1-800-711-4555, Option 1** (5 a.m.-7 p.m., PT, Monday – Friday, 6 a.m.-3 p.m., PT, Saturday).

Quantity Limits: Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions.

Step Therapy means that coverage of a requested medication is approved only if you have tried certain other medications first and they did not work, or if you have specific medical conditions which preclude you from trying the alternatives. Step therapy is managed automatically when you bring your prescription to the pharmacy to be filled. The pharmacist will be able to tell you when he or she processes your prescription whether or not it is covered by your prescription plan.

OptumRx Specialty Pharmacy Program: Certain medications used for treating chronic or complex health conditions are handled through the Specialty Pharmacy. This program assists you with monitoring your medication needs for certain conditions and by providing patient education. Specialty medications are limited to a 30-day supply and may be obtained only at the Specialty Pharmacy. Call the Specialty Pharmacy at **1-866-702-8423** Fax **1-800-853-3844** or **OptumRx.com** for further information.

Features of Your OptumRx Pharmacy Plan Online

Members enrolled in the medical plan can view pharmacy information online by going to **www.yctrust.net** then click on Prescription Coverage, from there you can access the **OptumRx.com** website.

- **Copay and Drug Information** – allows you to compare copays at specific pharmacies or the Mail Service Pharmacy service so you can compare and save.
- **Search the Formulary** – research medications to determine whether they are generic, preferred or non-preferred drugs; this will determine which copay is required.
- **Download the Formulary** – print a copy for you and your doctor.
- **Locate and Map a Nearby Pharmacy** – view pharmacies in your area by zip code including 24-hour pharmacies.
- **Go Mobile** – sign up for text reminders to take and refill your medications.
- **Order Online** – order medical supplies and health and wellness products.
- **Mail Service Forms** – register for mail order service.
- **Prescription History** – view your prescription history.
- **Refill Information** – view refill information; find out when your next refill can be ordered.
- **Drug Information** – research information on uses of the drug, side effects, precautions, and interactions.
- **Product News** – view latest product news available, including drug recalls and industry advances.
- **Area In-Network Pharmacies Include** but are not limited to Safeway, Fry's, WalMart, CVS, and Walgreens.

Prescription Drug Tiers

1st Tier – Generics contain the same active ingredient as their brand name equivalents and are manufactured to offer the same effectiveness and safety. Generics generally have the lowest copay. Some low-cost brands may be included.

2nd Tier – Medications in this tier have been selected by your pharmacy benefit plan (OptumRx) as preferred brand drugs. These drugs have higher copays than generics, but are less costly than non-preferred medications on the 3rd tier.

3rd Tier – If your medication has a generic version or 2nd tier alternative available, these will be considered as non-preferred medications. Non-preferred medications have the highest copays and are not listed on the Preferred Medication List (also called a Formulary).



Q: What pharmacies can I use?

A: You can find a participating pharmacy online. Visit **www.yctrust.net** and click on Prescription Coverage, from there you can access the **OptumRx.com** website.

Q: Where can I find the OptumRx Formulary?

A: You can view or print the OptumRx Formulary online at **OptumRx.com**.

Q: How long does it take to get a prescription through the mail service pharmacy?

A: Allow 10 business days from the date you place the order to receive your medication. You can order by mail, or your physician can fax or E-prescribe. If you need your medication right away, request a prescription for an initial 30-day supply to fill at your local pharmacy as well as one for a 90-day supply with three refills to fill through the mail order service.

THE MEDICAL PLAN *continued*

The chart below shows highlights and a comparison of your medical plan and prescription drug benefits. All admissions, plus procedures and treatment over \$1,000 must be precertified. Except in an emergency, Out-of-Network claims are paid in accordance with the Plan's definition of Allowed Charges. For more detailed information, see your YCT Plan Document.

Medical Plan Highlights and Comparison

Benefit Description	Premier Plan		Basic Plus Plan
	In-Network ¹	Out-of-Network ³	In-Network PPO Providers Only
Plan Year Deductible (July 1 - June 30) (deductible applies to most charges unless otherwise specified)	\$300/person; \$600/family	\$300/person; \$600/family	\$600/person; \$1,200/family
Out-of-Pocket Limit For July 1 - June 30	\$3,000/person; \$6,000/family	No out-of-pocket maximum	\$6,000/person; \$12,000/family
Emergency Room	After you pay a \$100 copay per visit the plan pays 80%	After you pay a \$100 copay per visit the plan pays 80%	After you pay a \$100 copay per visit the plan pays 60%
Urgent Care	80%	60%	60%
Hospital Admission	80%	60%	60%
Primary Care Physician (PCP) • Office Visits • Other Physician Services	\$20 copay/visit (deductible waived) 80%	60% 60%	60% 60%
Maternity Services	After you pay a \$100 copay the plan pays 80%	After you pay a \$100 copay the plan pays 60%	After you pay a \$100 copay the plan pays 60%
Lab (Non-hospital)	100% (deductible waived)	60%	100% (deductible waived)
Alternative Health Care Services (Acupuncture, Naturopathic and/or Chiropractic Services have a yearly benefit limit)	80%	60%	60%
EAP	Up to 3 free visits per plan year with an EAP counselor per problem per person, by calling 1-800-321-2843.		
Behavioral Health/Substance Abuse • Outpatient • Inpatient	\$20 copay/visit (deductible waived) 80%	60% 60%	60% 60%
Wellness – Birth to 18 months (deductible waived)	100% after \$20 copay/visit	100% after \$20 copay/visit	100% after \$20 copay/visit
Wellness – 19 months & older	Plan pays 100% up to \$300 (deductible waived) then plan pays 10% after deductible is met. Routine wellness related blood/lab tests covered at 100% in-network (deductible waived).		
Recommended Immunizations	100% (deductible waived)	100% (deductible waived)	100% (deductible waived)
Retail Network Pharmacy²	Up to a 30-day supply (deductible does not apply)		Up to a 90-day supply (deductible does not apply)
Tier 1 – Generic	\$10 copay		\$30 copay
Tier 2 – Preferred Brand	20% of drug cost, \$100 copay max		20% of drug cost, \$300 copay max
Tier 3 – Non-preferred Brand	50% of drug cost, \$20 copay min/\$150 copay max		50% of drug cost, \$60 copay min/\$450 copay max
Mail Order In-Network Only	Up to a 90-day supply (deductible does not apply)		
Tier 1 – Generic	\$15 copay		
Tier 2 – Preferred Brand	\$40 copay		
Tier 3 – Non-preferred Brand	\$100 copay		

¹ Percentage paid is based on the PPO Allowance. Deductible applies to all benefits except where otherwise specified.

² Formulary-listed drugs only. If the drug cost is less than the copay, you pay the cost of the drug.

³ Plan pays up to the allowed charges after the deductible has been met. You may be responsible for the difference between the billed charges and the amount this Plan allows. Deductible applies to all benefits except where otherwise specified.

High Deductible Health Plan

In-Network¹

Out-of-Network³

\$2,500/person; \$5,000/family⁴

\$2,500/person; \$5,000/family

\$10,000/person; \$20,000/family

100% after deductible

100% after deductible

50% of the Allowed Charge after deductible

100% after deductible

50% of the Allowed Charge after deductible

100% after deductible

50% of the Allowed Charge after deductible

100% (deductible waived)
prenatal and postnatal office visits

50% of the Allowed Charge after deductible

100% after deductible

50% of the Allowed Charge after deductible

100% after deductible

50% of the Allowed Charge after deductible

Up to 3 free visits per plan year with an EAP counselor per problem per person, by calling 1-800-321-2843.

100% after deductible

50% of the Allowed Charge after deductible

100% (deductible waived)

50% of the Allowed Charge after deductible

100% (deductible waived)

50% of the Allowed Charge after deductible

100% (deductible waived)

50% of the Allowed Charge after deductible

100% after deductible

50% of the Allowed Charge after deductible

100% after deductible

50% of the Allowed Charge after deductible

Two Medical Plans Are “Grandfathered” For 2016

This group health plan (sponsored by Yavapai Combined Trust) believes that the Premier Plan and the Basic Plan options are considered to be a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the above noted plan options may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your HR Department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform/>. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Designation of a Primary Care Provider (PCP)

The medical plans offered by YCT do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of an out-of-network provider.

Direct Access To OB/GYN Providers:

You do not need prior authorization (pre-approval) from YCT or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional 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, go online to www.yctrust.net.

Privacy Notice Reminder

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan’s HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. You can get another copy of this Notice from your HR Department or the plan’s website at www.yctrust.net.

Women’s Health And Cancer Rights Act Of 1998 (WHCRA) Reminder

You or your dependents 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 stages 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.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information, contact your HR Department.

⁴ **SPECIAL NOTE:** For families enrolled in the HDHP with HSA option, IRS regulations require that the family (including any individual in the family) must meet the family deductible (e.g. \$5,000) before any reimbursement is made for eligible medical expenses (other than for preventive care).

DENTAL AND VISION PLANS

DENTAL PLAN

The **Freedom of Choice** plan offers two dental plan options. Dental coverage is independent of medical coverage. You can elect to participate in a dental plan even if you waive medical coverage.

Listed below is a comparison of your dental plan options. For more detailed information, see your YCT Plan Document.

Dental Coverage Options

You may choose to waive coverage or elect from the following dental options:

- Comprehensive Plan; or
- Preventative Plan.

Coverage Levels

Under dental plan coverage, you may elect:

- Employee Only; or
- Employee + Family.

Comprehensive Plan

The Comprehensive Plan provides a higher level of benefits.

Preventative services are covered at 100%, with no deductible. The Comprehensive Plan covers basic services (for example, fillings), major services (for example, inlays, onlays, crowns), and orthodontic services (for example, braces), after you satisfy the annual deductible. To receive care, simply visit any dentist. Then, you or your dentist must submit a claim form to be reimbursed for services.

Preventative Plan

The Preventative Plan is a low-cost option which covers preventative dental services such as oral cleanings, exams, and X-rays. Preventative care is covered 100% with no deductible. To receive care, simply visit any dentist. Then, you or your dentist must submit a claim form to be reimbursed for services.

Dental Plan Benefits Highlights and Comparison

Benefit Description	Comprehensive Plan	Preventative Plan
Annual Deductible (July 1 - June 30)	\$50 per person; \$150 per family	\$0
Annual Maximum (July 1 - June 30)	\$1,500	\$250
Preventative Services (subject to annual dental maximum)	100%, no deductible	100%, no deductible
Basic Services (including fillings, extractions, oral surgery)	80%	Not covered
Major Services (including onlays, crowns, dentures)	50%	Not covered
Orthodontic Services (for children up to age 18 who have participated in the dental plan for 24 consecutive months.)	50%	Not covered
Lifetime Orthodontic Maximum (not subject to annual dental maximum)	\$1,500	Not applicable



Q: How do I choose a dentist?

A: The Trust does not have a network for dentists. Therefore, you can go to any dentist you choose.

Q: If I choose only the dental plan coverage, will I receive a YCT ID card?

A: Yes. Contact your HR Department.

Q: How do I choose a vision provider?

A: The Trust does not have a specific vision network. You can go to any vision provider or use those found in the BCBSAZ network.

Q: Do you have to pay up front?

A: Sometimes. When you make your appointment, ask how they bill.

VISION PLAN — For Yavapai College, Yavapai County and Town of Chino Valley only

Vision coverage (if available) can be elected even if you waive medical and/or dental coverage.

Coverage Levels

Under vision plan coverage, you may elect:

- Employee Only; or
- Employee + Family.

The vision plan provides a \$300 per plan year benefit per person to be used for any eligible expenses (except those listed as excluded in the YCT Plan Document) that may include vision exams, lenses and frames, prescription sunglasses, and contact lenses.

To receive vision care, simply visit **any** optometrist, ophthalmologist, or optician. Then, you or your vision care provider must submit a claim form to be reimbursed for services.

For more detailed information, see your YCT Plan Document.

ADDITIONAL INSURANCE

BASIC LIFE INSURANCE

Basic Life Insurance coverage is automatically provided to all eligible employees on the first day of employment or on the date you become benefits-eligible with a participating employer. If you enroll your spouse or dependent child(ren) for coverage in one of the Trust's medical plan options, they automatically receive dependent basic life insurance coverage. The minimum benefit varies for each participating employer, but is no lower than a \$10,000 benefit for employees up to a maximum benefit of \$50,000. The spouse benefit is \$2,000 and dependent children benefit is \$1,000. For more information, contact your HR Department.



Reminder:
It's a good idea to review and update your beneficiary information during Open Enrollment; however, you can do this anytime by contacting your HR Department.

Supplementing your employer-provided life insurance with voluntary life will add to the financial protection of your family.

VOLUNTARY LIFE INSURANCE

In addition to your employer-paid life insurance, you have the option to purchase **Voluntary Life Insurance**. You can purchase coverage for yourself, your spouse and your dependent child(ren). To enroll, complete and sign the Voluntary Life Insurance Form.

Coverage Options

You may elect to waive coverage or choose employee Voluntary Life Insurance coverage in increments of \$10,000, to a maximum of \$500,000.

For your spouse, you may elect Voluntary Life Insurance up to 50% of your coverage in \$5,000 increments, up to a maximum of \$250,000.

You may also elect the following Voluntary Life Insurance coverages for your dependent child(ren):

- waive coverage;
- \$2,000;
- \$5,000; or
- \$10,000.

Evidence of Insurability (EOI)

If you did not enroll for Voluntary Life Insurance coverage as a new employee or if you want to increase coverage, then you must provide evidence of insurability by completing the Medical History form and be approved for coverage.

You are not required to provide evidence of insurability if:

- you are a new hire and eligible for this coverage for the first time, **and**
- you are electing the guarantee issue of \$50,000 for employee, \$20,000 for spouse coverage, or \$10,000 per child.

Voluntary Life Insurance Rates

Voluntary Life Insurance rates for you and your spouse are based on age. The rates are listed on the Voluntary Life Insurance Worksheet/ Enrollment Form available from your HR Department. Premiums for voluntary life insurance benefits are set up through payroll deductions on an after-tax basis.

You can elect Voluntary Life Insurance any time during the plan year (may be subject to evidence of insurability).

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance provides weekly income benefits if you cannot work due to a non-occupational, accidental injury or illness (including pregnancy). This coverage is provided automatically to plan participants by participating employers.



FLEXIBLE SPENDING ACCOUNTS (FSAs)



You can continue to file claims until September 30, 2017 for expenses incurred between July 1, 2016, and June 30, 2017.



Flexible Spending Account Program – The Smart Way to Pay for the Things You Need

You have the option to participate in a Health Care and/or Dependent Care Flexible Spending Account and use tax-free dollars to pay for the things you need. Whether you have medical bills or day care costs, you can save on qualified expenses through the Flexible Spending Account Program.

Highlights of the Flexible Spending Account Program

- The plan year for the Flexible Spending Accounts is July 1, 2016 through June 30, 2017.
- You choose the annual amount to be deducted from your paychecks.
- The maximum amount you can deposit each plan year to an FSA:
Health Care – \$2,500 to use to pay medical expenses not covered by your medical, dental and vision plans such as copays, deductibles and out-of-pocket expenses.
Dependent Care – up to \$5,000 to use toward the costs of dependent day care services for eligible children and other qualifying dependents. The IRS sets limits under various circumstances. You may be eligible to claim the dependent care tax credit on your federal income tax return. Consult your tax advisor to determine which gives you the greater advantage.
- You choose the annual amount to contribute, which is deducted from your check before taxes are taken out, lowering your taxable income and your taxes.
- Pre-tax funds are deposited into your Health Care and/or Dependent Care account via payroll deduction. If you elect to contribute to the Health Care FSA, your total annual contribution is available to use at time of election. However, if you contribute to the Dependent Care FSA, only the amount deposited each pay period is available to use.
- When you first enroll, you will receive an FSA “my benny” card in the mail.
- You can use your FSA “my benny” card to pay for qualified purchases at many merchants and service providers, or you can mail in a claim form for reimbursement.
- Replacement cards can be obtained by calling Summit Administration Services, Inc. and paying a \$10 replacement cost.
- Unused amounts do not carry over to the next plan year.
- The Claims Administrator is Summit Administration Services, Inc. For more information, please contact Summit Administration Services, Inc. at **1-888-690-2020**.

You must enroll in a Flexible Spending Account each year if you want to participate.

- It is recommended you keep ALL receipts for all FSA-eligible expenses.
- If you lose your FSA “my benny” card, there is a \$10 replacement cost.
- Once you use up your contributions for the plan year, do not throw the card away. It will continue to be good in future plan years, as long as you re-enroll and contribute to the FSA program.

Manage Your FSA Online

- 1.** Visit www.yctrust.net and click on Flexible Spending Accounts. This will connect you to **mybenny.com**
 - 2.** To register, click on “Please register”
 - 3.** Then, enter your member ID located on your medical ID card, FSA debit card number and your zip code.
 - 4.** New, unregistered FSA cardholders will input an email address (this will be your user name and MUST be in email format). The card holder will then create a password.
- When you login to your account, you can view and print transaction activity, view the balance in your FSA account and edit your profile such as your password or email address. To order a replacement FSA “my benny” card, please contact Summit Administration Services, Inc. at **1-888-690-2020**.

Flexible Spending Accounts Life Events/Mid-Year Changes

You cannot change your elections to your Health Care and/or Dependent Care Flexible Spending Accounts after enrollment unless you have a special enrollment event. For more information, see page 15.

Plan Carefully!

It is important to plan carefully and set aside only as much money in your FSA as you intend to use each plan year. IRS regulations require that all money contributed to your FSAs must be used to pay for expenses incurred during that plan year only. Otherwise your money is forfeited.

You can continue to file claims until September 30, 2017 for eligible expenses incurred during the plan year between July 1, 2016 and June 30, 2017. You can use the money in your account to pay eligible expenses incurred by any of your qualified dependents even if they are not covered under your health plan.

If You Elect the HDHP with an HSA

If you are electing to enroll in the HDHP with an HSA, **you will not be able to have any contributions to your HSA** if you enroll in a general purpose Health FSA. However, if you have a **“limited”** purpose Health FSA which covers eligible expenses for dental and vision care only, you will still be able to contribute to your HSA.

To find out more about contributing to a limited purpose Health Care FSA, contact your HR Department.



You can manage your Flexible Spending Accounts anytime by visiting www.yctrust.net.

Use Your Flexible Spending Account to Help Pay for Eligible Expenses Not Covered Under Your Plan

Health Care Expense Examples

Eligible expenses for reimbursement are defined by the IRS. In general, you can use the money in your FSA to pay for eligible health care expenses that are not covered by your insurance.

For a general purpose Health Care FSA, eligible health care expenses include your deductible and copays for prescription drugs or medical, dental or vision care. You can also use your account to pay for expenses that exceed your plan benefit limits or to pay for care if you are not enrolled in the dental or vision plan.

Remember, over-the-counter medicines or drugs are NOT eligible for reimbursement from an FSA without a physician's prescription. Insulin is an exception, and may still be purchased using your Health Care FSA.

For a limited purpose Health Care FSA, eligible Health Care expenses include dental and vision care.

Dependent Care Expense Examples

Eligible expenses under this type of account are expenses incurred for dependent care that is necessary so you can be gainfully employed.

This dependent care can be for any member of your household who is a dependent and meets the following general government stipulated definitions of eligible dependents:

- A **“qualifying child”** up to age 13 (older if physically or mentally incapable of self-care) and has the same principal residence as the employee for more than half of the year.
- A **“qualifying relative”** of any age who has a gross income of less than a certain amount. Day care services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes. You will need to provide the tax I.D. number of the day care provider on submitted claims.

If you are taking care of an elderly or disabled adult, their eligible expenses can only be reimbursed if they meet the definition of a qualifying relative.

The types of care that might need to be paid to care for an elder or disabled adult that allows you, the employee to be able to work, could include adult day care or sitters; however, elder care expenses are reimbursable only if:

- The expenses are not attributable to medical services; and
- In cases where the service is provided outside the employee's home, the elderly person still spends at least 8 hours each day in the employee's home.



WELLNESS BENEFITS



Nothing is more important than your health.

If your goal is to improve your health and wellness, or even if you are just thinking about it as a future goal, the YCT Wellness Program can help get you on track.

Visit our website at yctwellness.com to get more information about classes and events and learn how we can help you to take action today.

The YCT Wellness Program is available to benefit eligible employees of Yavapai College, Yavapai County, City of Prescott, and Town of Chino Valley, as well as their spouses and dependents.

Visit yctwellness.com today to get started.

Mission Statement:

“To empower each employee to take control of their own health and wellness by making informed decisions every day”



OTHER BENEFIT INFORMATION

Get more information on all your benefits at www.yctrust.net or call your HR Benefit Specialist.

The Claims Administrator is Summit Administration Services, Inc., which is responsible for processing all the claims for medical, dental, vision and short-term disability; provides verification of benefits and eligibility, as well as administers the FSA Plan and COBRA. Contact Summit Administration Services, Inc. by calling **1-888-690-2020** or access their website at www.yctrust.net.

The Precertification Administrator is American Health Group, Inc. (AHG). AHG helps to assure all treatments are medically necessary and appropriate. All admissions and treatments and/or services that are greater than \$1,000 require precertification. For more information, call **1-800-847-7605**.

The Mammography Program is part of the YCT Wellness coverage benefit, which currently provides ONE FREE SCREENING (not subject to the Wellness annual maximum benefit) per year to women who are 30 years of age or older.

The Employee Assistance Program (EAP) is administered by Holman Frazier, LLC. This is a free and confidential resource to assist you and your family members in managing issues that affect your daily life such as family or marital conflicts, stress, depression and alcohol or drug issues.

The EAP provides face-to-face counseling sessions with a licensed clinician, legal and financial resources, and community referrals to a variety of wellness-related resources such as 12-step programs, parenting classes and elder care referrals. Using your EAP can be the first step to regaining control and improving your quality of life. Participation is completely confidential and stays out of your medical and personnel file.

You can receive up to **three FREE** and confidential visits with a counselor for yourself or an eligible family member for each unique non-related problem each benefit year. You can also receive unlimited access to information online and community referrals.

For more EAP information, call **1-800-321-2843** from 7:30 a.m. to 6:30 p.m. PST to speak with a qualified intake specialist who will assist you with your needs. If you feel that your situation requires immediate assistance, you can ask to speak to a licensed clinician, 24 hours a day, 365 days a year. You can also go to www.holmangroup.com/holmanfrazier/ enter user name: holmanfrazier; password: YCT3950 (case sensitive), select “Member,” then “log in.”

IMPORTANT PLAN INFORMATION

Mid-Year Changes To Your Health Care Benefit Elections

IMPORTANT: After this open enrollment period is completed, generally you will not be allowed to change your benefit elections or add/delete dependents until next year's open enrollment, unless you have a Special Enrollment Event or a Mid-year Change in Status Event as outlined below:

Special Enrollment Event: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 your 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 towards the other coverage).

In addition, 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 dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact your HR Department.

Mid-Year Change in Status Event: Because the Trust pre-taxes benefits, we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year. The following events may allow certain changes in benefits mid-year, if permitted by the IRS:

- Change in legal marital status (e.g. marriage, divorce/legal separation, death).
- Change in number or status of dependents (e.g. birth, adoption, death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a QMCSO.
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify the plan in writing within 31 days of the mid-year change in status event by contacting your HR Department. The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Important Reminder to Provide the Plan With the Taxpayer Identification Number (TIN) or Social Security Number (SSN) of Each Enrollee in a Health Plan

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: <http://www.socialsecurity.gov/online/ss-5.pdf>. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact your HR Department.

COBRA Coverage Reminder

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace. See www.healthcare.gov. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs. That notice should be sent to HR Department via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA contact Summit Administration Services, Inc.

Availability Of Summary Health Information: The Summary Of Benefits and Coverage (SBC) Documents(s)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages the SBC should be (maximum 4-pages, 2-sided), the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

The SBC for each medical plan option is included in your printed enrollment packet. To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for your medical plan options, go to www.yctrust.net or contact your HR Department.

Caution: If You Decline Medical Plan Coverage Offered Through YCT

The medical plan options offered by YCT are considered to be minimum essential coverage (MEC) and meets the government's minimum value standard. Additionally, the cost of medical plan coverage is intended to be affordable to employees, based on employee wages.

If you are in a benefits-eligible position and choose not to be covered by one of YCT's medical plan options, you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment in the fall each year.

Americans without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Health Insurance Marketplace for detailed information on individual shared responsibility payment penalty at <https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/>.

If you choose to not be covered by an YCT medical plan at this enrollment time, your next opportunity to enroll for YCT's medical plan coverage is at the next annual open enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of YCT's plan year.

You Must Be Qualified To Contribute To A Health Savings Account

The eligibility requirements to open and contribute to a Health Savings Account (HSA) are mandated by the Internal Revenue Service (IRS), not by your employer. Individuals who enroll in a Health Savings Account (HSA) but are later determined to be ineligible for that account, are subject to financial penalties from the IRS. It is an individual's responsibility to ensure that they meet the eligibility requirements to open an HSA account and to have contributions made to that HSA account, as outlined below:

- To be eligible to open an HSA and have contributions made to the HSA during the year, an individual must be covered by an HSA-qualified health plan (an HDHP) and must not be covered by other health insurance that is not an HSA-qualified plan. Certain types of insurance are not considered "health insurance" and will not jeopardize an individual's eligibility for an HSA, including automobile, dental, vision, disability, and long-term care insurance.
- **IMPORTANT:** Individuals enrolled in Medicare aren't eligible to open a HSA or have contributions made to the HSA during the year. If you think you could become eligible for Medicare in the next 12 months you should reconsider whether enrolling in the medical plan that is paired with a health savings account is a wise choice.
- Not be claimed as a dependent on someone else's tax return.
- Individuals can't open an HSA, and have contributions made to the HSA during the year, if a spouse's health insurance, general purpose health care flexible spending account (FSA) or health reimbursement arrangement (HRA) can pay for any of an individual's medical expenses before the HSA-qualified plan deductible is met. This means that a standard general purpose health care flexible spending account (FSA) may make you ineligible to open an HSA and have contributions made to the HSA during the year.

If you are electing to enroll in a new high deductible health plan with a health savings account (HSA) you will not be able to have any contributions to your HSA if you enroll in a general purpose Health FSA. However, if you have a limited purpose Health FSA you can have contributions to your HSA. For more information, contact your HR Department.

Medicare Notice Of Creditable Coverage Reminder

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, the prescription drug coverage that you elect from YCT under the Premier Plan, the Basic Plus Plan, or The High Deductible Health Plan is creditable with (as valuable as) Medicare's prescription drug coverage.

For more information, review the Plan's Medicare Part D Notice of Creditable Coverage available online at www.yctrust.net.





www.yctrust.net

This Enrollment Guide contains highlights of the Yavapai Combined Trust benefits program. Complete information can be found in the Plan Document/Summary Plan Description. If there is a conflict between this Guide and the Plan Document/Summary Plan Description, the Plan Document/Summary Plan Description will prevail. The Yavapai Combined Trust reserves the right to amend, replace or terminate any benefit program at any time for any reason. If one of these events occurs, you will be notified. Receipt of this Guide does not guarantee benefits eligibility.

TRUST PLAN CONTACTS

If You Need More Information About...	Contact...
<ul style="list-style-type: none"> ● Medical, Dental and Vision Claims ● Eligibility ● COBRA Administration ● HIPAA Certificate of Coverage ● Short-Term Disability (for employees of participating employers of the Trust) ● FSA Administration 	Summit Administration Services, Inc. P.O. Box 25160 Scottsdale, AZ 85255-0102 1-888-690-2020 or 1-480-505-0400 M – TH 8:00 a.m. – 5:00 p.m. F 8:00 a.m. – 4:30 p.m. Fax: 1-480-505-0406 www.yctrust.net
<ul style="list-style-type: none"> ● Utilization Management Program ● Precertification of Medical/Surgical Services ● Medical Review Services ● Case Management Services 	American Health Group, Inc. (AHG) 2152 S. Vineyard Ave., #103, Mesa AZ 85210 1-602-265-3800 or 1-800-847-7605 www.americanhealthgroup.com
<ul style="list-style-type: none"> ● Medical Preferred Provider Network (PPO Preferred In-Network Providers) ● Network Behavioral Health Providers 	Blue Cross Blue Shield of Arizona (BCBSAZ) www.azblue.com Blue Preferred PPO Network
<ul style="list-style-type: none"> ● Health Savings Account Administration 	Health Equity Member Services: 1-866-346-5800 www.healthequity.com
<ul style="list-style-type: none"> ● Employee Assistance Program (EAP) ● Contracted EAP Counselors 	Holman Frazier, LLC 7418 E. Helm Drive, Suite 236, Scottsdale, AZ 85260 1-800-321-2843 www.holmangroup.com user name: holmanfrazier; password: YCT3950 (case sensitive) select member and log in
<ul style="list-style-type: none"> ● Retail/Mail Order Prescription Drug Program ● Retail Network Pharmacies ● Prescription Drug Information and Formulary ● Prior Authorization of Drugs ● Specialty Managed Drugs 	OptumRx Customer Service: 1-800-797-9791 Clinical Prior Authorization: 1-800-711-4555 Option 1 OptumRx Specialty Pharmacy: 1-866-218-5445 Home Delivery Mail Service: Customer Service: 1-800-797-9791 (TTY: 711) www.yctrust.net or OptumRx.com
<ul style="list-style-type: none"> ● Yavapai Combined Trust (YCT) 	Plan Administrator: Wendy Ross Phone: 928-771-3252 Fax: 928-771-3419 www.yctrust.net
<ul style="list-style-type: none"> ● Yavapai College 	Human Resources Director 1100 E. Sheldon Prescott, AZ 86301 Phone: 928-776-2211 Fax: 928-776-2202
<ul style="list-style-type: none"> ● City of Prescott 	Benefits Specialist 201 S. Cortez, Prescott, AZ 86303 Phone: 928-777-1347 Fax: 928-777-1213
<ul style="list-style-type: none"> ● Yavapai County 	Human Resources Director 1015 Fair Street, Rm. 338 Prescott, AZ 86305 Phone: 928-771-3252 Fax: 928-771-3419
<ul style="list-style-type: none"> ● Town of Chino Valley 	Human Resources Department 202 N. State Route 89 Chino Valley, AZ 86323 Phone: 928-636-2646 Fax: 928-636-1977