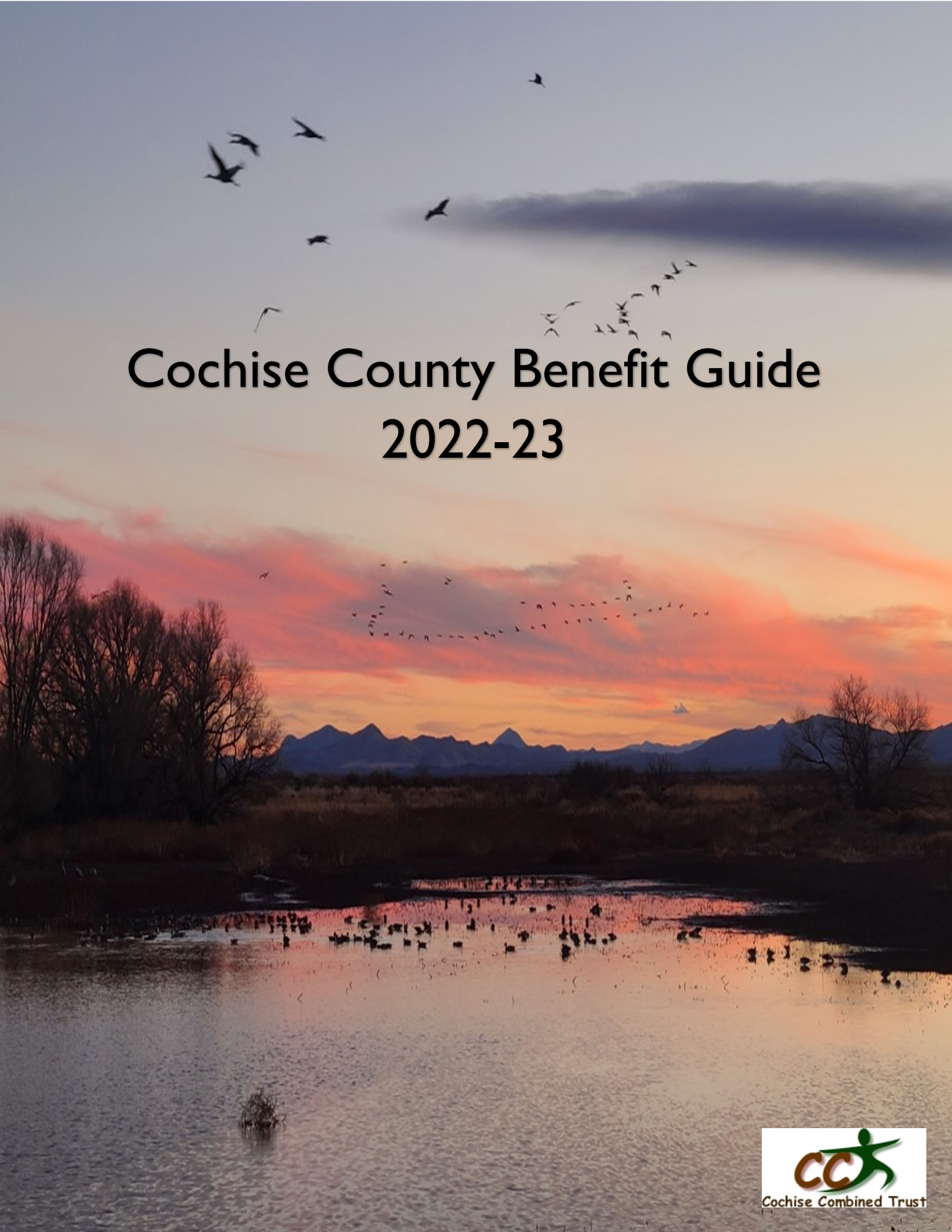

Cochise County Benefit Guide
2022-23

Cochise Combined Trust

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Benefit Enrollment

What is Open Enrollment?

Open enrollment is your opportunity to review your benefits and make changes to your coverage, add, or remove a dependent from coverage. Open enrollment begins April 1 and ends April 30 each year.

- Review Insurance Coverage and select plans Medical/Rx EPO or HDHP, Dental, and Vision
- Choose Tier (employee only, employee plus spouse, employee plus children or employee plus family)
- Elect Flexible Spending Account (FSA) or Health Savings Account (HSA)
- Elect Dependent Daycare Flexible Spending Account (DDC FSA)
- Enroll, change, or terminate Voluntary Benefits

The cost of healthcare continues to be a significant concern. To help control healthcare costs, we all need to take an active role in our healthcare options and choose a healthier lifestyle. Better choices include utilizing Teladoc and urgent care instead of the emergency room, when appropriate, choosing generic medications and participating in on-site preventive screenings and wellness programs. Making wise choices in how you spend healthcare dollars can make a difference in the future of all our healthcare costs.

ENROLLMENT NOTES

Medical/Rx, Dental, Vision, Flexible Spending Accounts and Dependent Day Care are paid with pre-tax dollars. Therefore, you can only enroll or change this coverage during open enrollment unless you experience a qualifying mid-year event. More information about qualifying events located on page 4.

Other voluntary benefits, such as voluntary term life insurance can be enrolled in or changed at any time.

Enrollment Dates and Deadlines

Employees who are:	Enrollment Deadline	Effective date of coverage	Documentation required
Currently Active	**April 30, 2022**	**July 1, 2022**	**Marriage and/or birth certificate or other court document for newly added spouse and/or dependents**
New hire or rehire	**Must enroll within 31 days of hire**	**First of the month following date of hire**	**Marriage and/or birth certificate or other court document for added spouse and/or dependents**
Making a status change from Part-time to full-time or full-time to part-time	**Must enroll within 31 days of status change**	**First of the month following status change**	**Marriage and/or birth certificate or other court document for added spouse and/or dependents**
Having a qualified event	**Must enroll within 31 days of qualifying event**	**Day of the life event**	**Marriage and/or birth certificate or other court document for added spouse and/or dependents and proof of life event**
Terminating employment	**Benefits automatically end**	**Last day of the month in which employee terminates**	**N/A**

What is a Qualifying Life Event?

- Marriage, divorce, legal separation, annulment, or death of a spouse
- Birth, adoption, legal guardianship, or death of a dependent child
- The beginning or end of an employee's or spouse's employment
- A change in your or your spouse's benefits eligibility status (e.g., a reduction or increase in hours of employment that may occur when switching between part-time and full-time, the start or end of an unpaid leave of absence, or spouse's open enrollment)
- A dependent child becoming eligible or ineligible for coverage
- You, your spouse, or a dependent child becoming ineligible for other coverage
- Entitlement to Medicare by yourself, your spouse, or a dependent child

What is New for the 2022-23 Plan Year?

EPO and EPO Buy-Up Changes for 2022-23

Add genetic testing/counseling for treatment only and subject to precertification

Add coverage for offsite preventative 3D Mammograms

Increase Non Health Care Reform Preventative Wellness to $750 including $100 in off-site non-required

HDHP Changes for 2022-23

Add genetic testing/counseling for treatment only and subject to precertification

Add coverage for offsite preventative 3D Mammograms

Increase Non Health Care Reform Preventative Wellness to $750 including $100 in off-site non-required

Non-Network Maximum Out of Pocket $200,000/$400,000

High Deductible Health Plan	HDHP with HSA	
Plan Features	In-Network	Out-of-Network
Plan Year Deductible **See page #9 for the definition of embedded**	Embedded	Embedded
Per member	$3,000	$5,000
Per Family	$6,000	$10,000
Out-of-Pocket Maximum	Embedded	Embedded
Per Member	$3,000	$200,000
Per Family	$6,000	$400,000
Preventive Care		
All Healthcare Reform plus $750 towards non-required preventive services	100% No Deductible	Not Covered
Annual on-site HRA/Biometrics	100% No Deductible	Not Covered
Hospital, Physician and Other Services		
Inpatient Hospital	0% after deductible	50% after deductible
Outpatient Facility	0% after deductible	50% after deductible
Office Visit Primary Care Physician (PCP)	0% after deductible	50% after deductible
Office Visit Specialist	0% after deductible	50% after deductible
Teladoc	0% after deductible	50% after deductible
Urgent Care	0% after deductible	50% after deductible
Emergency Room (ER)	0% after deductible	0% after In-Network deductible
Non-Emergency at ER	Not Covered	Not Covered
Chiropractic Care – Limit of 20 visits	0% after deductible	50% after deductible
Maternity	0% after deductible	50% after deductible
Diagnostic Test Lab/X-ray	0% after deductible	50% after deductible
Advanced Imaging	0% after deductible	50% after deductible
Durable Medical Equipment	0% after deductible	50% after deductible
Behavioral Health and Substance Abuse		
Outpatient visits PCP	0% after deductible	50% after deductible
Outpatient visits Specialist (Psychiatrist)	0% after deductible	50% after deductible
Inpatient Behavioral Health	0% after deductible	50% after deductible

Coinsurance numbers reflect the percentage of approved charges paid by the plan participant.

Spending Accounts Available with HDHP

	HSA - Health Savings Account	DDC FSA – Dependent Day Care Account
Definition	An employee funded account used to pay for qualified health care expenses* (medical, Rx, dental and vision)	An employee funded account used to pay for qualified child and adult day care expenses* with pre-tax dollars
Who is eligible?	Employees enrolled in the High Deductible Health Plan.	Employees
Who is covered?	Employees enrolled in the High Deductible Health Plan as well as spouse and dependents claimed on taxes	Children younger than 13 and disabled adult dependents claimed on income taxes (must reside with you more than 50% of the year)
What is the annual contribution amount?	$3,650 for single coverage $7,300 for family coverage $1,000 catch-up contribution for those over 55	$5,000
When are my funds available?	As contributed (funds must be in account before they can be used)	As contributed (funds must be in the account before they can be used)
Can I change my election mid-year?	Yes. You may start, stop, increase, or decrease anytime of the year.	Yes, with a qualifying life event.
Can I have more than one type of Spending Account?	Yes, you can have an HSA and a Dependent Day Care FSA.	Yes, you can have a Dependent Day Care FSA and an HSA or FSA Account.
Do my unused funds carry over to the next year?	Yes, unused funds rollover from year to year.	No
Can I take the account with me if I change employers or retire?	Yes, you can continue to utilize your HSA funds even if you are no longer enrolled in a qualified HDHP. However, to continue contributing you must be enrolled in a qualified HDHP.	No
Is this a tax advantaged plan?	Yes, funds contributed through payroll deduction are pre-tax. After tax contributions are tax deductible.	Yes, funds contributed through payroll deduction are pre-tax.
Can I use the funds for retirement income?	Yes. After age 65, you can withdraw funds for any reason. If funds are not used for qualified health expenses, withdrawals will be taxed as income.	No
Does the account earn interest?	Yes	No
Is there a monthly fee?	Yes, there is a monthly fee until you reach a minimum balance of $2,500 then it is waived.	No
Where can I go to find out what kind of expenses are qualified for this account?	https://www.irs.gov/pub/irs-pdf/p502.pdf	https://www.irs.gov/pub/irs-pdf/p503.pdf

Traditional Medical plans	Traditional Cost-sharing (EPO)	Traditional Cost-sharing Buy-up
Plan Features	In-Network	In-Network
Plan Year Deductible See page #9 for definition of embedded	Embedded	Embedded
Per member	$500	$250
Per Family	$1,500	$750
Out-of-Pocket Maximum	Embedded	Embedded
Per Member	$6,000	$4,500
Per Family	$14,300	$11,000
Preventive Care		
All Healthcare Reform plus $750 towards non-required preventive services	0% No Deductible	0% No Deductible
Annual on-site HRA/Biometrics	0% No Deductible	0% No Deductible
Hospital, Physician and Other Services		
Inpatient Hospital	20% after deductible	20% after deductible
Outpatient Facility	20% after deductible	20% after deductible
Office Visit Primary Care Physician (PCP)	$25 copayment	$25 copayment
Office Visit Specialist	$35 copayment	$35 copayment
Teladoc	First two (2) visits per plan participant free, then $35 copayment	First two (2) visits per plan participant free, then $35 copayment
Urgent Care	$35 copayment	$35 copayment
Emergency Room (ER)	$250 copayment, then deductible and coinsurance	$250 copayment, then deductible and coinsurance
Non-Emergency at ER	Not Covered	Not Covered
Chiropractic Care – Limit of 20 visits	$25 copayment	$25 copayment
Maternity	$25 copayment initial visit the 20% coinsurance after deductible	$25 copayment initial visit the 20% coinsurance after deductible
Diagnostic Test Lab/X-ray	Under $500 $25 PCP or $35 Specialist Copayment; Over $500 20% coinsurance after deductible	Under $500 $25 PCP or $35 Specialist Copayment; Over $500 20% coinsurance after deductible
Advanced Imaging	20% after deductible	20% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible
Behavioral Health and Substance Abuse		
Outpatient visits	$25 copayment PCP or $35 copayment Specialist	$25 copayment PCP or $35 copayment Specialist
Inpatient – Limit of 30 days per plan year and 60 days lifetime	20% after deductible	20% after deductible

Coinsurance numbers reflect the percentage of approved charges paid by the plan participant.

Spending Accounts Available with Traditional Cost-Sharing (EPO)

	Health Care FSA Flexible Savings Account	DDC FSA Dependent Day Care Account
Definition	An employee funded account used to pay for qualified health care expenses* (medical, Rx, dental and vision)	An employee funded account used to pay for qualified child and adult day care expenses* with pre-tax dollars
Who is eligible?	Employees enrolled in the Traditional Cost-Sharing Plan	Employees
Who is covered?	Employees enrolled in the Traditional Cost-Sharing Health Plan as well as spouse and dependents under age 27.	Children younger than 13 and disabled adult dependents claimed on income taxes (must reside with you more than 50% of the year)
What is the annual contribution amount?	$2,850	$5,000
When are my funds available?	All funds are available on the day of the first payroll in the plan year.	As contributed (funds must be in the account before they can be used)
Can I change my election mid-year?	Yes, with a qualifying life event.	Yes, with a qualifying life event.
Can I have more than one type of Spending Account?	Yes, you can have a Health Care FSA and a Dependent Day Care FSA.	Yes, you can have a Dependent Day Care FSA and an HSA or FSA Account.
Do my unused funds carry over to the next year?	Unused funds up to $570 roll over into the next plan year.	No
Can I take the account with me if I change employers or retire?	No	No
Is this a tax advantaged plan?	Yes, funds contributed through payroll deduction are pre-tax.	Yes, funds contributed through payroll deduction are pre-tax.
Can I use the funds for retirement income?	No	No
Does the account earn interest?	No	No
Is there a monthly fee?	No	No
Where can I go to find out what kind of expenses are qualified for this account?	https://www.irs.gov/pub/irs-pdf/p502.pdf	https://www.irs.gov/pub/irs-pdf/p503.pdf

General Medical Plan Information:

Medical/Rx Benefit Terms & Billing

What is a co-payment? A co-payment is the fee charged by a provider for a covered medical expense or a covered prescription drug expense at the time the service/prescription is received for those on the EPO plan.

What is a deductible? The deductible is the amount of covered medical expenses the participant pays each plan year before benefits are paid by the plan. For example, if the deductible is $500, then you must pay the first $500 of the covered medical costs before the plan will pay. The deductible amount must be met first before coinsurance applies.

What does embedded mean? An embedded deductible means that each participant has their own deductible and once that amount has been satisfied, the plan will start paying coinsurance.

What is coinsurance? Coinsurance is generally shown as a percentage of covered expenses over and above the deductible. For example, doctor and facility visits may be covered on an 80/20 coinsurance. This means the plan covers 80%, or $4,800, of a $6,000 facility bill, and the participant is responsible for the remaining 20% or$1,200, up to the maximum out-of-pocket amount.

How does my maximum out-of-pocket work? Each plan specifies an out-of-pocket maximum. Once this amount is met for the plan year, the plan covers all eligible charges at 100%. Co-payments and deductibles accumulate toward the maximum out-of-pocket amount.

The HDHP has a $3,000 per participant and $6,000 per family maximum out-of-pocket for in-network providers, and $200,000 per participant and $400,000 per family maximum out-of-pocket for out-of-network providers. The maximum out-of-pocket is embedded. This means the plan will cover 100% of the approved in-network charges for a participant once the individual participant meets $3,000 and will cover 100% of approved in-network charges once employee plus children, spouse or family reaches $6,000 in the plan year.

The EPO Plan has a $6,000 per participant and $14,300 per family maximum out-of-pocket. The maximum out of pocket on the EPO plan is embedded. This means the plan will cover 100% of the approved charges for a participant once the individual participant meets $6,000. The plan will cover 100% of approved charges once employee plus children, spouse or family reaches $14,300 in the plan year.

How does a facility bill for medical services? Is this my only bill for these medical services, or can I expect to receive others? When you receive a facility bill for services, it includes many costs: facility charges, equipment, supplies, laboratory/radiology services, and other support services. You may expect to receive bills for medical services from the facility, as well as from the physician, and/or other providers who supplied medical services. As a result of government regulations, most facility-based physicians and specialists separately bill their services from the facility. The separate bill will be from your physician, surgeon, anesthesiologist, or other independent supplier of medical services. The chart below gives examples of medical services that require the attention of a physician who will send a separate bill for payment. For instance, if you have x-rays taken, you may also receive a bill from the radiologist that reads the x-rays or a pathologist who reviews a lab test. If you have a surgery, you may also receive a bill from an assistant surgeon or an anesthesiologist.

When you are sick… Consider Teladoc!

- It is convenient
- It is quick
- It saves you money
- It saves the Trust money

Avoid expensive emergency room visits by using Teladoc. The average cost of an E.R. visit is $1,912. You may be responsible for a copayment, deductible and coinsurance depending on which plan you are enrolled in so it may cost you between $250 to $1,912. Compare this to $55 for HDHP members or $35 for Traditional EPO members (first two visits per plan year are free).

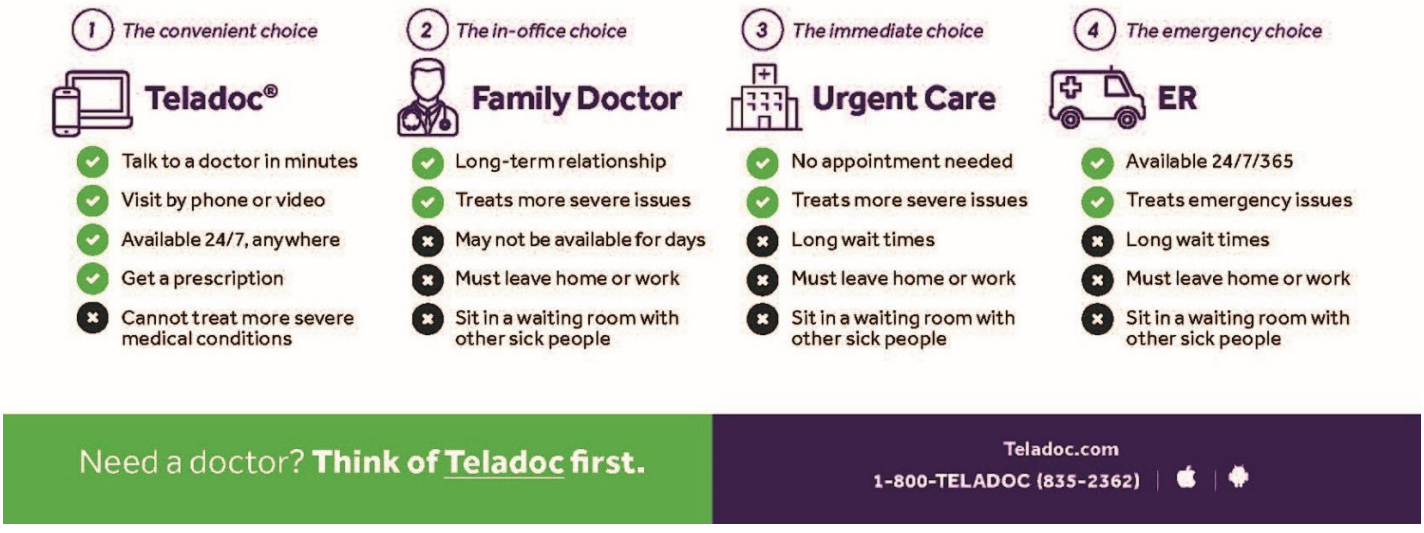
Connect with an experienced board-certified physician to treat common issues like:

- Cold and Flu Symptoms
- Allergies
- Bronchitis
- Skin Problems
- Respiratory infections
- Sore throat
- Sinus problems and more!

They will even call a prescription in to your regular or the nearest pharmacy when medically necessary.

It's Easy!

Create an account and complete the medical history today. It will save you time when you are ready to see the Doctor.



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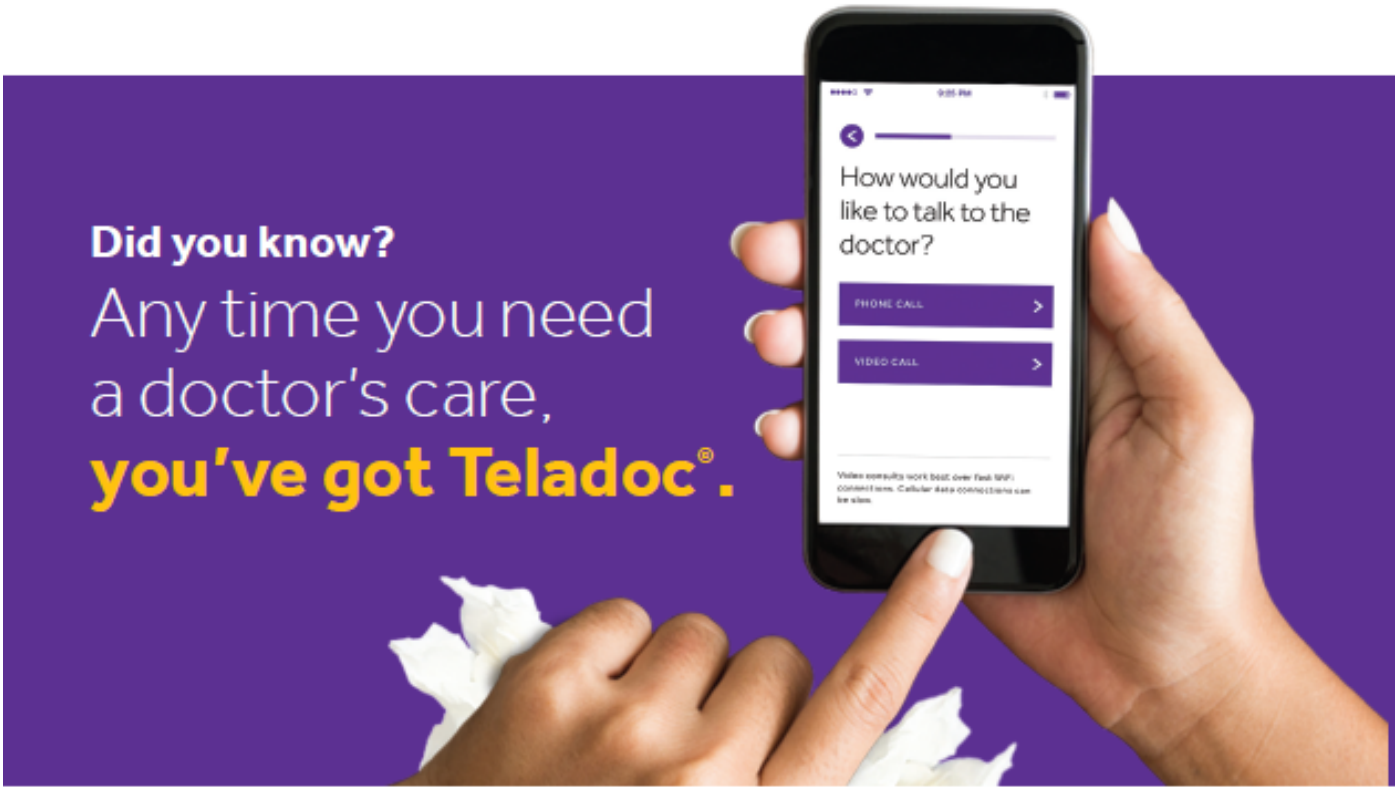
Cochise Combined Trust



Did you know?

Any time you need a doctor's care, **you've got Teladoc®.**

24/7/365 care for:
Cold & flu, allergies, rash and much more!

Licensed doctors
U.S. board-certified doctors average 20 years of experience

In minutes
Connect with a doctor by phone or video

Get a diagnosis
Our doctors recommend treatment and prescribe medication (when medically necessary)

$55 on HDHP

First two visits FREE then $35 copy on the Traditional (EPO) Plan

Speak with a doctor now!

Teladoc.com | 1-800-TELADOC (835-2362)

App Store Google Play

Prescription Drug Information

The prescription drug program is administered by Navitus. You are automatically enrolled in the prescription drug plan when you enroll in the medical plan.

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.

Checking your Formulary

You can find the CCT formulary on the Navitus member portal. You can browse by category of use or look up alphabetically. Also included is information about which drugs need prior authorization or have quantity limits. The coverage or tier for each drug product is noted but the dollar amount you pay for each medication is not listed on the site. See the Pharmacy Benefit Schedule on page 14 for cost-sharing information.

Customer Service

You can find additional information about your prescription drug plan at www.navitus.com, or contact Navitus Customer Service at 866.333.2757. Both resources are available 24 hours a day, 7 days a week.

Mail Order

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

It is easy to enroll:

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, faxing it to 888.545.4615 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.

What is a Pharmacy Benefit Manager (PBM)?

A PBM directs prescription drug programs and processes prescription claims by negotiating drug costs with manufacturers, contracting with pharmacies, and building and maintaining formularies. These cost-saving strategies help lower drug costs and promote good health.

How do I find out about my benefits online?

You can sign up to access the portal at www.navitus.com. Whether it is helping you to find a local pharmacy or reviewing your medication profile, the member portal will provide you with the information to take control of your personal health.

Where can I find my formulary?

The list of drugs covered by your benefit is available on our website at www.navitus.com then select "Members" at the top of the page. In the middle of the page, you will see the Member Portal Login.

How do I get additional Pharmacy ID Cards?

You can request additional medical/Rx ID cards through the AmeriBen portal.

When can I refill my prescription?

Your prescription can be refilled at a retail pharmacy when approximately 75% of the prescription has been taken.

What if I am going to be traveling away from home?

If you are traveling for less than a month, any Navitus Network Pharmacy can arrange in advance for you to take an extra one-month supply. If you are traveling form more than a month, you can request your pharmacy transfer your prescription to another network pharmacy located in the area you are traveling to.

Can prescriptions be mailed to me if I am outside of the United States?

Prescriptions cannot be legally mailed from the mail order pharmacy or any pharmacy in the U.S. to locations outside the U.S.

Prior Authorization

Your physician will be required to obtain prior authorization from Navitus to prescribe specific medications. Navitus' Pharmacy and Therapeutics Committee creates guidelines to promote effective prescription drug use for each prior authorization drug. These guidelines are based on clinical evidence, prescriber opinion and FDA-approved labeling information. Some types of clinical evidence include findings of government agencies, medical associations, national commissions, peer reviewed journals, authoritative summaries, and opinions of clinical experts in various medical specialties.

Pharmacy Schedule of Benefits

Preferred Pharmacy	**HDHP**	**Traditional Cost - Sharing EPO**	**Traditional Cost-Sharing EPO Buy-up**
Prescription Drug Maximum Out-of-Pocket (OOP) per Plan Year			
Per Plan Participant	Included in the Medical Max OOP	Included in the Medical Max OOP	Included in the Medical Max OOP
Per Family Unit	Included in the Medical Max OOP	Individual Rx Maximum out of pocket is embedded in the Family Medical Max Out-of-pocket	Individual Rx Maximum out of pocket is embedded in the Family Medical Max Out-of-pocket
Retail Pharmacy Option (30-day supply)			
Tier 1: most formulary generics and certain low-cost brand	0% after deductible	$10 copayment	$10 copayment
Tier 2: Most formulary brands and certain high-cost generics	0% after deductible	$30 copayment	$30 copayment
Tier 3: Non-formulary brands and generics	0% after deductible	$60 copayment	$60 copayment
Specialty Tier	0% after deductible	$100 copayment	$100 copayment
90-day Retail or Mail Order Pharmacy Option			
Tier 1: most formulary generics and certain low-cost brand	0% after deductible	$20 copayment	$20 copayment
Tier 2: Most formulary brands and certain high-cost generics	0% after deductible	$60 copayment	$60 copayment
Tier 3: Non-formulary brands and generics	0% after deductible	$120 copayment	$120 copayment
Preventive Medications			
Certain preventive care prescription drugs mandated under Healthcare reform are covered at 100% with no participant cost-sharing when obtained from an in-network. An expanded list of 100% covered preventive medications is available to HDHP members.			

Common Pharmacy Terms

Brand Drug: A drug with proprietary, trademarked name, protected by a patent by the U.S. Food and Drug Administration (FDA). The patent allows the drug company to exclusively market and sell the drug for a period of time. When the patent expires, other drug companies can make and sell a generic version of the brand-name drug.

Formulary: A list of drugs that are covered under your benefit plan.

Generic Drugs: Prescription drugs that have the same active ingredients, same dosage form and strength as their brand-name counterparts.

Prescription Drug: Any drug you may obtain by prescription only.

Prior Authorization: Approval from Navitus for coverage of a prescription drug. See Prior authorization pg. 13 for more information.

Specialty Drug: Drugs, such as self-injectable and biologics, typically used to treat patients with chronic illnesses or complex diseases.

Therapeutic Equivalent: Similar drug in the same drug classification used to treat the same condition.

Rates and Contributions

	Traditional Plan (EPO)			
	Employee	Employee/Spouse	Employee/Child	Employee/Family
Monthly Rate	$615.20	$1,083.42	$905.81	$1,313.79
Monthly County Contribution	$563.76	$810.41	$732.81	$940.79
Employee Cost Per Pay Period*	$23.74	$126.00	$79.85	$172.15
	Traditional Plan (EPO Buy-Up)			
Monthly Rate	$669.24	$1,180.09	$983.98	$1,434.44
Monthly County Contribution	$582.01	$799.29	$724.64	$901.13
Employee Cost Per Pay Period*	$40.26	$175.75	$119.70	$246.14

	High Deductible Health Plan (HDHP)			
	Employee	Employee/Spouse	Employee/Child	Employee/Family
Monthly Rate	$562.44	$986.08	$822.41	$1,197.43
Monthly County Contribution	$561.01	$848.08	$734.41	$1,009.43
Employee Cost Per Pay Period*	$0.66	$63.69	$40.62	$86.77

	Dental			
	Employee	Employee/Spouse	Employee/Child	Employee/Family
Monthly Rate	$26.31			$74.60
Monthly County Contribution	$2.76			$8.78
Employee Cost Per Pay Period*	$10.87			$30.38
	Vision			
Employee Cost Per Pay Period*	$2.95	$5.61	$5.91	$8.59

*Rates are based on 26 pay periods per year.

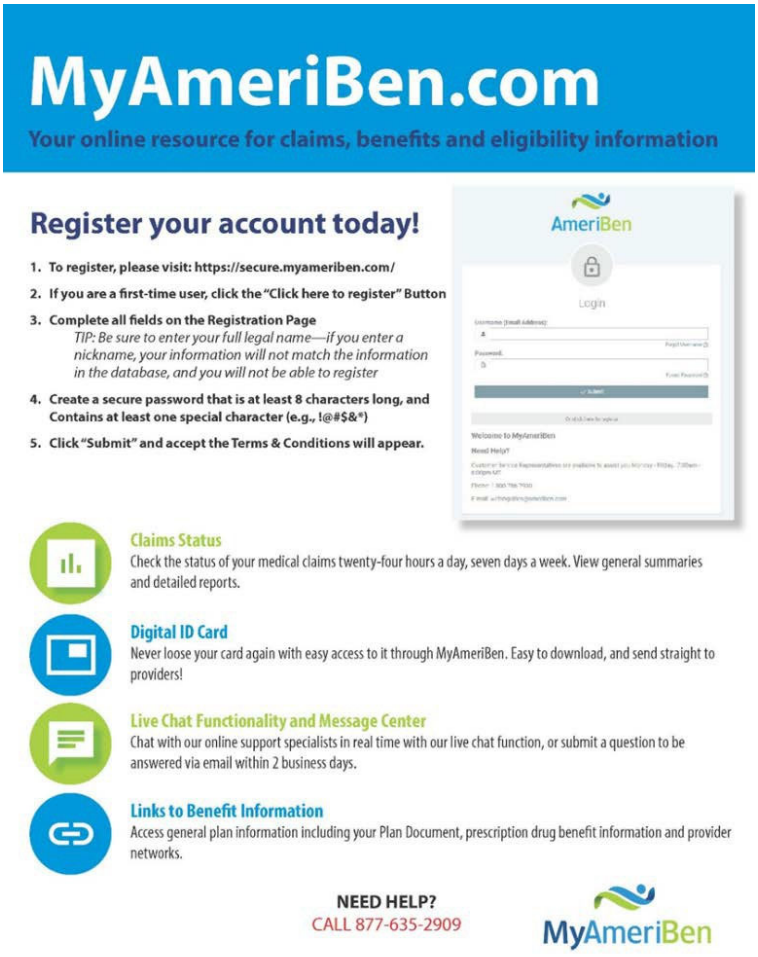
Network

You have access to a Find A Doctor tool that lists doctors, other healthcare professionals, hospitals, and facilities.

Log in to www.azblue.com/chsnetwork , choose Arizona PPO as your plan then click on "Find a Doctor."

You will be able to search for a provider in your plan's network by provider name, type of provider, or within a certain distance of your location. It's always good to check if providers are in your plan's network before you see them. If you have a PPO plan, like the HDHP, providers who are not in your plan's network will cost you more. If you have an EPO plan, providers who are not in your plan's network will not be covered by your plan. When talking with a provider, always ask, "Do you take my BCBSAZ plan?" Most providers are in a BCBSAZ network – but not all providers are in every BCBSAZ plan's network. That is why it is important to ask if they take your plan. You can also call the number on the back of your member ID card to determine providers are in your network.

Medical Claims Administration



AmeriBen, located in Meridian, Idaho, has over 50 years of experience administering benefits. It is a privately held company that was founded in 1958. They have over 900 employees located throughout the country and office locations in Boise, Salt Lake City, Phoenix, and Plano. AmeriBen operates with a core purpose of "Changing lives by developing great leaders in family, business, community and the world" and core values of "Integrity," "Initiative," "Good Judgement," and "Teamwork."

After you visit the doctor, in-network providers send the claim to BCBSAZ for repricing. BCBSAZ discounts it based on the agreement they have with that provider. Once repriced, it is sent to AmeriBen for processing and payment. AmeriBen compares the billing codes to the Summary Plan Description to verify the charges are for covered services. If approved, it is processed for payment. The provider will receive a check, and the participant will receive an Explanation of Benefits (EOB) explaining how the claim was paid. If you receive a bill from your provider and do not receive and EOB from AmeriBen, you should call AmeriBen at 1.855.258.6455 to inquire if they have received the claim or you can contact your provider to verify they have your correct insurance billing information. Non-network providers send their claims directly to AmeriBen for processing or payment. If it is a large claim (Over $5000), AmeriBen will attempt to negotiate with the facility or provider for a discount. Many times, they are successful, and this saves money for both the Trust and the Participant. If you have questions or would like assistance with understanding the plan, please call AmeriBen toll-free at 1.855.258.6455.

Dental Plan

Ameritas

Dental Plan Benefits

	In-Network	Out-of-Network
Type 1 Preventive No Waiting Period	100%	80%
	• Routine Exam (2 per Benefit Period) • Bitewing X-rays (1 per Benefit Period) • Cleaning (2 per Benefit Period)	• Routine Exam (2 per Benefit Period) • Bitewing X-rays (1 per Benefit Period) • Cleaning (2 per Benefit Period)
Type 2 Basic No Waiting Period	80%	50%
	• Surgical Extractions • Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Periodontics (nonsurgical) • Endodontics (surgical) • Periodontics (surgical) • Simple Extractions	• Surgical Extractions • Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Periodontics (nonsurgical) • Endodontics (surgical) • Periodontics (surgical) • Simple Extractions
Type 3 Major No Waiting Period	50%	40%
	• Crowns (1 in 5 years per tooth) • Prosthodontics (Bridges, Dentures) (1 in 5 years) • Implants	• Crowns (1 in 5 years per tooth) • Prosthodontics (Bridges, Dentures) (1 in 5 years) • Implants
Deductible		
Type 1	$0	$0
Type 2 and 3	$50 per person, per calendar year	$100 per person, per calendar year
Family Maximum	$150 per Benefit Period	$300 per Benefit Period
Plan Year Maximum		
Type 1, 2, and 3 (per person, per benefit period)	$2,000	$1,500
Orthodontia Benefits (children under age 17)		
No waiting period		
Plan Benefit	50%	50%
Lifetime Deductible	$0	$0
Lifetime Maximum (per person)	$2,500	$2,500
Claims Allowance		
Type 1, 2 and 3	Discounted Fee	80th U&C

To find an in-network provider for dental services, log onto the website at www.Ameritas.com and choose the PPO network or call customer service at 1-800-659-2223. Dependents are eligible until their 26th birthday.

Vision Plan

40%OFF

additional complete pair of prescription eyeglasses

20%OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

Cochise Combined Trust

SUMMARY OF BENEFITS		
VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit & Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $105
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $30
Bifocal	$10 copay	Up to $50
Trifocal	$10 copay	Up to $70
Lenticular	$10 copay	Up to $70
Progressive - Standard	$65 copay	Up to $50
Progressive - Premium Tier 1 - 4	$95 - 185 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $23
Anti Reflective Coating - Premium Tier 1 - 3	$57 - 85 copay	Up to $23
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $105
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $105
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	**ALLOWED FREQUENCY – ADULTS**	**ALLOWED FREQUENCY – KIDS**
Exam	Once every plan year	Once every plan year
Frame	Once every plan year	Once every plan year
Lenses	Once every plan year	Once every plan year
Contacts Lenses	Once every plan year	Once every plan year

(Plan allows member to receive either contacts and frame, or frame and lens services)

QL-0000038741

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

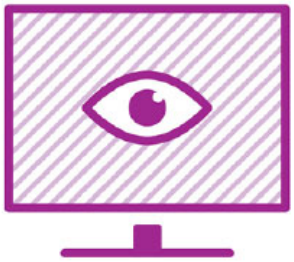
Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1] Based on weighted average of sample transactions: EyeMed Insight network/$10 exam copay/$10 materials copay/$120 frame or contact lens allowance.



Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

PDF-2004-M-377

Dependents are eligible until their 26th birthday.

Health Savings Account (HSA)

What is an HSA?

An HSA is an individual savings account that can be used to pay for qualified medical expenses. The HDHP option allows you to open an HSA and take advantage of terrific tax savings. The money in your account accumulates on a tax-deferred basis and can be rolled over from year to year. You can save your money for future medical expenses, and provided you use the money for a qualified medical expense, your funds are never taxed. This account is only available if you select the High-Deductible Health Plan (HDHP). A participant cannot contribute to an HSA if they are covered on any other non-qualified plan, are covered as a dependent on another person's tax return (excluding spouses), are enrolled in an FSA, or are enrolled in Medicare.

How Does an HSA Work?

A High-Deductible Health Plan offers a lower monthly premium in exchange for a higher deductible. The money you would normally spend on monthly premiums can now be contributed on a pre-tax basis to your HSA account. You will receive a debit card to use for qualified medical expenses, which will draw from your HSA. Distributions from your HSA are tax-free when used to pay for qualified medical expenses. The 2022 maximum contribution for single coverage is $3,650, and family is $7,300. HSA participants who are 55 or older can contribute an additional $1,000, or $4,650 for single coverage and $8,300 for family coverage. There is a $2.95 per month fee for your HSA Account until your account balance exceeds $2,500.

Does Cochise County contribute to my HSA?

When you enroll or re-enroll in a CCT HDHP, the County will contribute a total of $500 in bi-monthly contributions to your HSA. Participating in wellness related activities can earn you another $500. If your spouse is on our plan, their participation in wellness activities can earn you up to an additional $500! In addition, twice a year you will be provided the opportunity to convert excess PTO into up to $500 in HSA contributions.

Where to get more information

The Health Equity website is full of great information and the answers to all of your HSA questions including how to maximize your HSA account, why to maximize your account, who can use the funds from your HSA, how and where the funds can be used, what happens if you use the funds for a non-qualified purchase and more. www.healthequity.com.

Health Saving Account Information

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) is a Health Savings Account Qualified Plans

HealthEquity®
Building Health Savings℠

Under the **HDHP**, members must meet the plan year deductible before the plan benefits kick in. You may use your Health Savings Account (HSA) funds to pay for qualified medical expenses, including those incurred while meeting your deductible. If you exhaust your HSA funds, you pay any additional expenses required to meet your deductible out of your own pocket. Medical care and prescriptions are both subject to the deductible in this plan. The **in-network deductible** is $3,000 for an individual and $6,000 for a family and the separate **out-of-network deductible** is $5,000 for an individual and $10,000 for a family. Please note that if you have elected employee only coverage, the $3,000 individual deductible must be met before the plan will begin to pay for ANY benefits except preventive care. If you elect family coverage, once any one member reaches $3,000 in eligible expenses, the plan will begin to pay for their covered expenses; any combination of family members can meet the family deductible of $6,000.

Once you have met the applicable in network or out of network deductible, your care is covered through the plan's **coinsurance** as outlined in the summary plan description. The plan pays 100% of eligible charges for services provided in-network and 50% of eligible charges for services provided out-of-network.

You are responsible for your share of coinsurance until reaching the plan's out-of-pocket maximum. The out-of-pocket maximum is the most you will pay for eligible services during the plan year. Once you reach the maximum, the plan will pay 100% of eligible charges. The **out-of-pocket maximum** for **in-network services** is $3,000 for an individual and $6,000 for a family; **out-of-network out-of-pocket maximum** is $200,000 individual and $400,000 family. The out-of-pocket maximums include the deductible and coinsurance.

Your costs and the plans expense will generally be lower when utilizing a Blue Cross Blue Shield of AZ (BCBSAZ) provider or facility. This is good for everyone! HDHP includes coverage for out-of-network providers and facilities, so if you have a non-emergency desire or need to use a non-BCBSAZ provider or facility, you will be covered, however, keep in mind the out-of-network provider will result in a higher maximum out of pocket.

Participants in the HDHP are eligible to contribute to a Health Savings Account.

FLEXIBLE SPENDING ACCOUNTS

Under Section 125 of the IRS code, your employer sponsors a pre-tax cafeteria plan known as a Flexible Spending Account (FSA). This plan provides you with a convenient way to pay for certain expenses with pre-tax dollars savings from FICA, federal, and sometimes even state taxes. Through the plan, you set aside a portion of your earnings to pay for medical/dental/vision/ prescription expenses such as co-pays not covered by insurance. The plan also allows for earned income to be set aside for child daycare expenses.

Dependent Daycare eligible expenses are for children under the age of 13 and dependents of any age who are physically or mentally unable to care for themselves. By enrolling in this plan, you save money on child daycare expenses incurred so that you (and your spouse, if married) can work, look for work, or attend school on a full-time basis.

The County offers you the opportunity to participate in the following flexible spending accounts:

Unreimbursed Medical (URM) Account – Employees may elect to participate in the unreimbursed medical account, which is a cost-effective way to pay for predictable, eligible health care expenses that comply with the rules defined by the IRS. Such expenses typically are items not covered by health care insurance, such as co-payments for doctor visits and prescriptions. By paying for these expenses through an FSA before federal, social security, and state taxes are taken out, your taxable income is reduced. The maximum medical reimbursement amount allowable in FY 2022-23 is $2,850. Cochise County has chosen to provide you with the $570.00 carryover option for your Flexible Benefit Plan. This allows you to carry over up to $570.00 of unused funds at the end of the Plan Year into the next Plan Year. Any account with funds greater than $570.00 must be claimed by the end of the fiscal year (June 30) or they will be forfeited under the "use-it-or-lose-it" rule. Your plan also includes an FSA debit card to facilitate the use of your FSA contributions by allowing participants to pay for services at point of sale, without having to send in a request for reimbursement. **This does not mean that you will not have to submit documentation for any expenses paid for with the card.**

Dependent Day Care (DDC) Account - Employees may also elect to participate in the dependent day care account which allows them to pay for dependent care expenses with tax-free dollars for eligible dependents. Maximum amount is $5,000 or $2,500 if married or filing separate. For more information on the DDC account go to https://www.irs.gov/pub/irs-pdf/p503.pdf

As a reminder, you must re-enroll in the medical reimbursement or dependent care plan each year.

THE FUNDS ELECTED CAN ONLY BE USED FOR EXPENSES INCURRED DURING THE PLAN YEAR.

Your Human Resources Department will guide you on how to enroll or re-enroll in this benefit

GROUP VOLUNTARY LIFE INSURANCE

There are no changes to the voluntary life insurance benefit for the 2022-23 plan year. However, premium rates are adjusted on 7-1-2022 for the employee and spouses that move into a new age band. If you, your spouse, or children are not enrolled or if you wish to increase amounts you may complete an application; however, evidence of insurability will be required. For benefits and rate information, please refer to the handout provided separately or call Human Resources. **Open Enrollment is an excellent time to review your beneficiary designation to determine if any changes should be made.**

NEW EMPLOYEE ASSISTANCE PROGRAM (EAP)

Starting July 1, 2022, the County will be shifting the Employee Assistance Program from AWP to CuraLinc. The CuraLink EAP will provide up to five (5) free counseling sessions each plan year (July 1 through June 30) for each type of issue you or any member of your household may encounter along with work-life assistance for financial and/or legal problems. These visits are completely confidential and are completely free to you and your household members *(not required to be on your Medical/Rx plan – just need to live in your household)*. To make a confidential appointment, please call 888-881-5462. You can also access a variety of information on their website at www.supportlinc.com. Brochures and more information are available in Human Resources.

supportlinc
EMPLOYEE ASSISTANCE

Counseling:
- Call 888-881-5462 to speak with a licensed clinician 24/7 with little to no wait time
- Access to a hand-picked network of experienced counselors
- All members of the household are covered.

Training:
- Interactive Webinars

Resources:
- Online library of premium articles
- Legal assistance
- Financial Expertise
- Personalized coaching
- Live help 24/7

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

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

In-the-moment support
Reach a licensed clinician by phone 24/7/365 for immediate assistance.

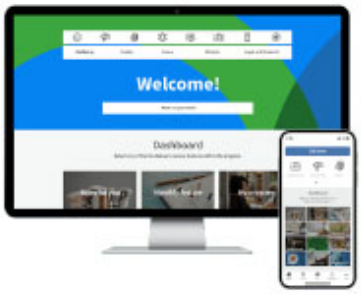
Financial expertise
Consultation and planning with a financial counselor.

Legal consultation
By phone or in-person with a local attorney.

Short-term counseling
Access up to **five (5) no-cost counseling sessions**, in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance abuse.

Convenience resources
Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.

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



Your web portal and mobile app
- The one-stop shop for program services, information and more.
- Discover on-demand training to boost wellbeing and life balance.
- Find search engines, financial calculators and career resources.
- Explore thousands of articles, tip sheets, self-assessments and videos.

Convenient, on-the-go support
- **Textcoach®**
  Personalized coaching with a licensed counselor on mobile or desktop.
- **Animo**
  Self-guided resources to improve focus, wellbeing and emotional fitness.
- **Virtual Support Connect**
  Moderated group support sessions on an anonymous, chat-based platform

Start with Navigator
Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator survey. You'll immediately receive personalized guidance to access support and resources.

supportlinc
EMPLOYEE ASSISTANCE

Download the mobile app today!

1-888-881-5462

supportlinc.com
group code:
cochisecombinedtrust

WELLNESS PROGRAM

Participation is the key to a successful Wellness Program and the key to a better quality of life for those who participate. Take the time to check out the Wellness Program being offered to you and your dependents as medical plan participants. It's good for your health!

Important Notices

Women's Health and Cancer Rights Act (WHCRA)

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:

1. all stages of reconstruction of the breast on which the *mastectomy* was performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance, prostheses
3. treatment of physical complications of the *mastectomy*, including lymphedema

This coverage is subject to the same *deductibles* and *co-payments* consistent with those established for other benefits under this *Plan*.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444- EBSA (3272).

If you live in the following State, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.

State	Website	Phone
Arizona • CHIP	http://www.azahcccs.gov/applicants	(Outside of Maricopa Co.): 1-877-764-5437 (Maricopa Co.): 1-602-417-5437

To research the availability of, and your eligibility for, premium assistance in other states, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/ebsa	www.cms.hhs.gov
1-866-444-EBSA (3272)	1-877-267-2323, Ext. 61565

Compliance with HIPAA Privacy Standards

HIPAA stands for the *Health Insurance Portability and Accountability Act of 1996*.

Certain members of the *employer's* workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the *Privacy Standards*), these *employees* are permitted to have such access subject to the following:

1. **General.** The *Plan* shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this Compliance with *HIPAA Privacy Standards* section is met. Protected Health Information shall have the same definition as set out in the *Privacy Standards* but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the *employer's* workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The *Plan's* administrative functions shall include all *Plan* payment and health care operations. The terms payment and health care operations shall have the same definitions as set out in the *Privacy Standards*, but the term payment generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill *Plan* responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. Health care operations generally shall mean activities on behalf of the *Plan* that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. *Genetic information* will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the *employer's* workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this Compliance with *HIPAA Privacy Standards* section, members of the *employer's* workforce shall refer to all *employees* and other persons under the control of the *employer*.
    a. Updates Required. The *employer* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    b. Use and Disclosure Restricted. An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the *Plan*.
    c. Resolution of Issues of Noncompliance. If any member of the *employer's* workforce uses or discloses Protected Health Information other than as permitted by the *Privacy Standards*, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised

ii. applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment

iii. mitigating any harm caused by the breach, to the extent practicable

iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages

4. **Certification of Employer.** The *employer* must provide certification to the *Plan* that it agrees to:

   a. Not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law.

   b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the *Plan*, agrees to the same restrictions and conditions that apply to the *employer* with respect to such information.

   c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *employer*.

   d. Report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law.

   e. Make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the *Privacy Standards*.

   f. Make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the *Privacy Standards*.

   g. Make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the *Privacy Standards*.

   h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *Privacy Standards*.

   i. If feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible.

   j. Ensure the adequate separation between the *Plan* and member of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the *Privacy Standards*.

5. The following members of the Cochise Combined Trust are designated as authorized to receive Protected Health Information from the Cochise Combined Trust (the *Plan*) to perform their duties with respect to the *Plan*:

   a. Account Executive (brokerage firm)

   b. Account Manager (brokerage firm)

   c. Assistant Vice President – Human Resources

   d. Human Resources Director/Associate Director

   e. Benefits Analyst

Compliance with HIPAA Electronic Security Standards

Under the *Security Standards* for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the *Security Standards*), the *employer* agrees to the following:

1. The *employer* agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the *employer* creates, maintains, or transmits on behalf of the *Plan*. Electronic Protected Health Information shall have the same definition as set out in the *Security Standards*, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

The *employer* shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Authorized Employees and Certification of Employers provisions, described above.

Reminder: If you are not requesting changes to your current benefit elections no action is required. The exception is the Flexible Spending Account which requires participants to complete new paperwork annually.

If you have any questions, please contact Lisa Culp or Brian Trevino at HumanResources@cochise.az.gov or call

(520) 432-9700

The text contained in the Benefit Guide was taken from the summary plan document and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this guide and the actual plan documents, the actual documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about open enrollment, please contact your Benefits Representative.