Yavapai Combined Trust (YCT) offers a comprehensive benefits program to help you and your family protect your health and financial security. Your YCT benefits are a valuable part of your compensation; we encourage you to learn how your plans work so you can maximize your benefits to meet your unique needs.

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. 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.

YCT is comprised of four entities: the City of Prescott, the Town of Chino Valley, Yavapai College, and Yavapai County. 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 regularly to discuss problems, solutions, and make recommendations to the Trustees at their quarterly meeting.
Introducing Your YCT Benefits Plan

Things To Remember As You Use This Enrollment Guide

It’s important that you 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. When enrolling, you may want to consider your needs for the coming 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 through June 30. If you do not enroll before your enrollment deadline, you will have to wait until the next open enrollment to be eligible for benefits unless you have a Special Enrollment Event or mid-year change in status, as defined on page 21 of this Guide.

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

- Elect or waive Medical, Dental and/or Vision coverage for yourself and qualified dependents.
- Elect 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 2019/2020 YCT Plan Document available online 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 a non-network provider, 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.
The YCT Benefits Plan

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

The YCT Benefits Plan offers:

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

How To Enroll

1. Read this Guide carefully for current information regarding your benefits.
2. Review your YCT Benefits Plan options to see which ones meet the needs for you and your family.
3. Careful planning is the key to getting the most from your benefits. You can compare your medical plan options and easily calculate your annual and monthly out-of-pocket cost for each Plan. Simply review your YCT Benefits Elections Form for details on your employee and employer's contributions.
4. You will need the social security number and date of birth for all dependents you enroll in the Plan.
5. Consider enrolling in a Health Savings Account (HSA) or Flexible Spending Account (FSA). You will need to submit a separate form for each account. See pages 8 and 18 for more information.
6. Consider supplementing your employer-provided life insurance with voluntary life. You can elect additional coverage for you, your spouse and your dependent children. See page 17 for more information.
7. Be sure to fill out the beneficiary information on the back of your YCT Benefits Elections Form even if you’re not electing additional voluntary coverage.
8. During your initial benefits enrollment period, you must enroll within 31 days of your date of hire or of becoming benefits-eligible.
9. You must return your completed forms to your HR Department by the enrollment deadline, or you will have to wait until the next open enrollment, unless you have a Special Enrollment Event or mid-year change in status, as described on page 21.
10. Watch your mailbox for your Member ID/Prescription Drug Cards within 14 days of the date you enroll for coverage.
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. You must return your completed forms to your HR Department by the enrollment deadline, or you will have to wait until the next open enrollment, unless you have a Special Enrollment Event or mid-year change in status, as described on page 21. You will also need to elect an FSA contribution 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 or mid-year change in status (see page 21 for more information).

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, 2019, 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.

Changing Your Coverage During The Year

Due to federal regulations, once you enroll in the YCT Benefits 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 Special Enrollment Event under HIPAA or mid-year change in status as defined by the IRS. See page 21 for details about allowable changes to your elections.

Q&A

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 or vice versa?
A: Yes. This is the beauty of the YCT Benefits Plan. You select the coverage that fits your needs.
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 2019 – 2020 plan year, you must indicate your contributions for the 12-month period when you enroll (see page 18 for more information).

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 Special Enrollment Event or 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 21 for details regarding mid-year changes to your elections.
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 (in accordance with a participating employer’s eligibility 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.
- Dependent children who lose coverage under the YCT Plan due to no longer meeting the age eligibility criteria for a “dependent child” will become Qualified Beneficiaries entitled to elect COBRA continuation of coverage. Refer to the COBRA coverage reminder on Page 21 for more information.

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, not by both. See your YCT Plan Document for the definitions of “spouse” and “dependent children.”
The Medical Plan

Your benefit 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 available at www.yctrust.net.

Medical Coverage Options

You may waive coverage or choose from the following options:

- Premier Plan
- Basic Plus Plan
- High Deductible Health Plan

Coverage Levels

Under the medical plan, you may elect coverage for:

- Employee Only
- Employee + Family

Premier Plan

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, but you may have to pay additional money out of your pocket if you use out-of-network providers. You will need to meet a separate out-of-network deductible for non-network providers and services, then eligible expenses are covered at 60%.

Basic Plus Plan

After you have met the in-network deductible, eligible in-network expenses are covered at 60%. You will need to meet a separate out-of-network deductible for non-network providers and services, then eligible expenses are covered at 50%.

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. You can find more on this HDHP option on page 7.

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 specific services.

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 has agreed to charge lower, pre-negotiated discount fees for eligible services. To find an in-network provider, go online to www.yctrust.net.


All of the YCT Medical Plans include the Preferred Provider Organization (PPO) network of providers which allow you to use any qualified provider you choose without a referral. To find an in-network provider, go online to www.yctrust.net.
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 then pays 100% for eligible expenses.

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.

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 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. After your deductible is met, the Plan’s coinsurance pays 100% for in-network services and 50% for out-of-network services. There are exceptions for certain preventive medications and medical services that are not subject to the deductible.

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).

Any money in your HSA will automatically roll over to future plan years, even if you are no longer enrolled in the HDHP. However, you are only able to contribute to your HSA when you are enrolled in an HDHP.
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.

Enrolling In A Health Savings Account

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. 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 2019–2020, if you are an active employee, you may contribute up to $3,500 for individual coverage, and $7,000 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. Anyone can contribute to your HSA; however, only your employee contributions will qualify for pre-tax savings. You can use your HSA debit card to pay for qualified expenses for you and any dependents that you claim on your tax return.

5 Reasons To Enroll In An HSA

1. Your employer may contribute 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 setting up payment schedules with a provider or have questions about a claim.

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 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.

Eligible Health Care Expenses

An HSA can help you pay for certain health care expenses that are not otherwise covered by the plan, including costs toward 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.

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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](http://www.irs.gov) and review Publication 502. If you still have questions, contact a Member Services specialist by calling Health Equity at [866-346-5800](tel:866-346-5800) anytime, day or night.

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.
Need to consult a doctor about a non-urgent illness, but can’t get an appointment with your primary doctor?

Teladoc allows you to meet with a U.S. board-certified doctor anytime, through phone and video consults.

Teladoc Gives You Choice, Convenience And Control

Teladoc is an on-demand health care solution that gives you access to the medical care you need, when you need it. You can talk to a doctor anytime, anywhere about non-emergency medical conditions.

What Kind Of Doctors Will I Be Talking With?

Teladoc offers highly qualified, experienced doctors who have an average of 10–15 years in practice, use the latest technology to provide excellent care, are U.S. board-certified and state licensed and specially trained in treating patients through telemedicine.

How To Reach Teladoc?

- **Register** — Log in to the Summit website at [www.summit-inc.net](http://www.summit-inc.net) and select TelaDoc from Quick Links
- **Call** — 800-362-2667
- **Online** — Request a video consultation online at [www.MyDrConsult.com](http://www.MyDrConsult.com)
- **On the go** — You can download the Teladoc mobile app by visiting the App Store or Google Play

Consulting With A Teladoc Provider Is Easy As 1–2–3.

You can have your appointment through the convenience of phone or video consults. Be sure to register ahead of time by visiting [www.summit-inc.net](http://www.summit-inc.net), sign in and click on TelaDoc under Member Quick Links. Then, whenever you feel unwell, it’s an affordable, convenient, quality care alternative for treating cold and flu symptoms, bronchitis, respiratory infection and more!

To schedule an appointment, log in to the Summit website at [www.summit-inc.net](http://www.summit-inc.net) to register and set up your account.

1. **Request a visit**
   Request a visit with a doctor 24 hours a day, 365 days a year, by web, phone, or mobile app.

2. **Speak with a doctor**
   Talk to licensed a healthcare professional and take as much time as you need...there’s no limit!

3. **Obtain a prescription if necessary**
   If medically necessary, a prescription will be sent to the pharmacy of your choice.
**Employee Assistance Program (EAP)**

*Life can pull you in many directions. Find your work-life balance with the Employee Assistance Program.*

The Employee Assistance Program (EAP) is administered by Jorgensen Brooks Group (JBG). Your EAP is a confidential benefit, pre-paid by your employer, that provides services to work closely with you to support you in challenging situations before they interfere with your home or work life.

All employees and their dependents/household members are eligible to access services 24 hours a day, seven days a week by calling JBG toll free at **888-520-5400**.

JBG offers Clinical Care services that include self-help groups, local in-person clinical counseling by licensed behavioral health professionals, telephone and internet chat support, referrals, treatment programs, and crisis intervention.

Our services are designed to support you with a wide range of emotional health issues such as marital relationships, parent/child conflicts, anxiety and stress, workplace issues, grief and loss, depression, dependent care concerns, wellness, substance abuse, and more. You may receive up to **6 free** counseling sessions per issue each year.

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**What Can I Use Teladoc For?**

Teladoc doctors can help with the following common medical conditions:

- Abscess
- Acid reflux
- Allergies
- Animal/insect bites
- Arthritis
- Asthma
- Blood pressure issues
- Bronchitis
- Bowel/digestive issues
- Cold/flu
- Croup
- Dizziness
- Eye/ear Infections
- Fever
- Headaches/m migraines
- Joint pain/swelling
- Laryngitis
- Pink eye
- Poison Ivy/Oak
- Rash/skin infections
- Sinus infections
- Sore throat
- Sprains & Strains
- Strep
- Stomachache/diarrhea
- Tonsillitis
- Urinary tract infections
- Yeast infections

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**When To Use Teladoc?**

Use Teladoc for medical advice and care when:

- Your primary care doctor isn’t available
- You’re at home or don’t want to take time off work to see a doctor
- When you are out of state or when geographical barriers exist
- You need a prescription or refills

*Note: There is no guarantee you will be prescribed medication.*

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**Who Can Use Teladoc?**

Anyone covered on your medical plan is eligible to use a Teladoc professional.

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- Laryngitis
- Pink eye
- Poison Ivy/Oak
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**Who Can Use Teladoc?**

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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 800-562-6223 (TTY: 800-735-2922).

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 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 Briova, the OptumRx Specialty Pharmacy at 855-427-4682, or fax to 877-342-4596. or log on to [OptumRx.com](http://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](http://www.yctrust.net) then click on Prescription Coverage, from there you can access the [OptumRx.com](http://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.

**Q&A**

**Q:** What pharmacies can I use?

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

**Q:** Where can I find the OptumRx Formulary?

**A:** You can view or print the OptumRx Formulary online at [OptumRx.com](http://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.

**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).
The table to the right shows a comparison of your medical plan and prescription drug benefits. All admissions, procedures or treatments over $1,000 require precertification. Except in the case of emergency services performed in an emergency room, an out-of-network provider may bill you for the difference between actual charges and those considered allowable by the Plan.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Premier Plan</th>
<th>In-Network¹</th>
<th>Out-of-Network³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Deductible (July 1 - June 30) (deductible applies to most charges unless otherwise specified)</td>
<td>$350/person; $700/family</td>
<td>$350/person; $700/family</td>
<td>The deductible for in-network providers does not accumulate to meet the deductible for out-of-network providers and vice versa.</td>
</tr>
<tr>
<td>Out-of-Pocket Limit (July 1 - June 30) (includes deductibles, copayments and coinsurance)</td>
<td>$3,350/person; $6,700/family</td>
<td>$3,350/person; $6,700/family</td>
<td>No out-of-pocket maximum</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>After you pay a $150 copay per visit the plan pays 80%</td>
<td>After you pay a $150 copay per visit the plan pays 80%</td>
<td></td>
</tr>
<tr>
<td>Urgent Room</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Hospital Admissions</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP) • Office Visits • Teladoc Online Services • Other Physician Services</td>
<td>$20 copay/visit (deductible waived) $20 copay 80%</td>
<td>$20 copay/visit (deductible waived) $0 copay 80%</td>
<td>60% Not covered 60%</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>After you pay a $150 copay the plan pays 80%</td>
<td>After you pay a $150 copay the plan pays 60%</td>
<td></td>
</tr>
<tr>
<td>Lab (Non-hospital)</td>
<td>100% (deductible waived)</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Alternative Health Care Services (Acupuncture, Naturopathic and/or Chiropractic Services have a yearly benefit limit)</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>EAP</td>
<td>Up to 6 free visits per plan year with an EAP counselor per problem per person, by calling 888-520-5400.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health/Substance Abuse • Outpatient • Inpatient</td>
<td>$20 copay/visit (deductible waived) 80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Wellness – Birth to 18 years (deductible waived)</td>
<td>100%</td>
<td>100% after $20 copay/visit</td>
<td></td>
</tr>
<tr>
<td>Wellness – 18 years &amp; older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommended Immunizations</td>
<td>100% (deductible waived)</td>
<td>100% (deductible waived)</td>
<td></td>
</tr>
<tr>
<td>Retail In-Network Pharmacy²</td>
<td>Up to a 30-day supply (deductible does not apply)</td>
<td>Up to a 90-day supply (deductible does not apply)</td>
<td></td>
</tr>
<tr>
<td>Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-preferred Brand</td>
<td>$10 copay 20% of drug cost, $100 copay max 50% of drug cost, $20 copay min $150 copay max</td>
<td>$30 copay 20% of drug cost, $300 copay max 50% of drug cost, $60 copay min $450 copay max</td>
<td></td>
</tr>
<tr>
<td>Mail Order In-Network Only</td>
<td>Up to a 90-day supply (deductible does not apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-preferred Brand</td>
<td>$15 copay $40 copay $100 copay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th>Medical Plan Highlights and Comparison</th>
<th>otherwise specified)(deductible applies to most charges unless specified)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3 –</td>
<td>Tier 2 –</td>
</tr>
<tr>
<td>Tier 1 –</td>
<td>Mail Order In-Network Only</td>
</tr>
<tr>
<td>Retail In-Network Pharmacy2</td>
<td>Recommended Immunizations</td>
</tr>
<tr>
<td>Wellness – 18 years &amp; older</td>
<td>100% (deductible waived)</td>
</tr>
<tr>
<td>Wellness – Birth to 18 years</td>
<td>100% after $20 copay/visit</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>80% 60%</td>
</tr>
<tr>
<td>Behavioral Health/Substance Abuse</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>80% 60%</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>Hospital Admission</td>
<td>After you pay a $150 copay per visit the plan pays 60%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>60% 50%</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>60% 50%</td>
</tr>
<tr>
<td>Up to a 30-day supply</td>
<td>50% 50%</td>
</tr>
<tr>
<td>(deductible does not apply)</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>Plan pays 100% (deductible waived)</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>Routine wellness related blood/lab tests covered at 100% in-network (deductible waived).</td>
<td>100% (deductible waived)</td>
</tr>
<tr>
<td>100% (deductible waived)</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>100% after deductible</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>Up to a 90-day supply</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>(deductible does not apply)</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>Up to a 90-day supply</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>(deductible does not apply)</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basic Plus Plan</th>
<th>High Deductible Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>$600/person;</td>
<td>$1,200/person;</td>
</tr>
<tr>
<td>$1,200/family</td>
<td>$2,400/family</td>
</tr>
<tr>
<td>The deductible for in-network providers does not accumulate to meet the deductible for out-of-network providers and vice versa.</td>
<td></td>
</tr>
<tr>
<td>$6,600/person;</td>
<td>No out-of-pocket maximum</td>
</tr>
<tr>
<td>$13,200/family</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>In-network covered services plus in-network outpatient drugs accumulate to the in-network out-of-pocket limit.</td>
<td></td>
</tr>
<tr>
<td>After you pay a $150 copay per visit the plan pays 60%</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>60% 50%</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>60% 50%</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>After you pay a $150 copay per visit the plan pays 60%</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>100% (deductible waived)</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>100% (deductible waived)</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>Up to 6 free visits per plan year with an EAP counselor per problem per person, by calling 888-520-5400.</td>
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</tr>
<tr>
<td>60% 60%</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>100%</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
<tr>
<td>Plan pays 100% (deductible waived). Routine wellness related blood/lab tests covered at 100% in-network (deductible waived).</td>
<td>100% (deductible waived)</td>
</tr>
<tr>
<td>100% (deductible waived)</td>
<td>50% of the Allowed Charge after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Up to a 30-day supply</strong> (deductible does not apply)</th>
<th><strong>Up to a 90-day supply</strong> (deductible does not apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>20% of drug cost, $100 copay max</td>
<td>20% of drug cost, $300 copay max</td>
</tr>
<tr>
<td>50% of drug cost, $20 copay min</td>
<td>50% of drug cost, $60 copay min</td>
</tr>
<tr>
<td>$150 copay max</td>
<td>$450 copay max</td>
</tr>
</tbody>
</table>

**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 & Vision Plans

The Trust does not have a network for dentists. Therefore, you can go to any qualified provider you choose.

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

Dental Plan Benefits Highlights and Comparison

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

Vision Plan

Vision coverage 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 that may include vision exams, lenses and frames, prescription sunglasses, or contact lenses.

To receive vision care, simply visit any optometrist, ophthalmologist, or optician (no claim form needed).

For more detailed information, see your YCT Plan Document.
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 maximum benefit varies for each participating employer, but is no lower than $10,000 for employees, $2,000 for your spouse and $1,000 for each dependent child. 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.

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

Eligible employees may elect 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 100% of your total basic and voluntary coverage in $5,000 increments, up to a maximum of $250,000.

You may also elect the following Voluntary Life Insurance up to 100% of your total basic and voluntary coverage for your dependent child(ren):

- $2,000
- $5,000
- $10,000
- $15,000 or
- $20,000
- $25,000
- $30,000
- $35,000
- $40,000
- $45,000
- $50,000
- $55,000
- $60,000
- $65,000
- $70,000
- $75,000
- $80,000
- $85,000
- $90,000
- $95,000
- $100,000
- $150,000
- $200,000
- $250,000
- $300,000
- $350,000
- $400,000
- $450,000
- $500,000

Note: If your spouse or child is eligible for employee coverage under any YCT location, they cannot be covered as a dependent. Only one employee may cover a dependent child.

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 Evidence of Insurability 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 $250,000 for employee, $50,000 for spouse coverage, or $20,000 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.

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.

Supplementing your employer-provided life insurance with voluntary life will add to the financial protection of your family.
Flexible Spending Accounts (FSAs)

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, 2019 through June 30, 2020.
- 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 ($2,700 for Yavapai College) 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 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. To log in to your Flexible Spending Account and access your FSA information, visit: https://summitmember.Lh1ondemand.com/

2. Your first login has a pre-assigned user name and password. You will use the 1st initial of your first name, full last name, and the last 4 digits of your SSN.
   Example:
   Joe Miller SSN xxx-xx-1234
   User name: jmiller1234
   PW: jmiller1234

3. You will be asked to immediately change your password upon your first login. These credentials also work on the free Summit Admin FSA App. The handy Mobile Application gives you on-the-go access to account balances and lets you submit claims and receipts with your smartphone camera. Search ‘Summit Admin FSA’ in the App Store or Google Play. Please call 888-690-2020 if you have any questions or need any assistance.

When you log in 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 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 21.

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

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, 2020 for eligible expenses incurred during the plan year between July 1, 2019 and June 30, 2020. 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 continue to file claims until September 30, 2020 for expenses incurred between July 1, 2019 through June 30, 2020.
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 elderly 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.

At YCT our mission focuses on a balance of physical and emotional wellness that empowers each employee to take control of their own health and wellness by making informed decisions every day. Take action today and start reaping the benefits of being yourself...at your best!

Annual mammography screenings are part of your wellness coverage. Your benefit provides ONE FREE SCREENING per year to eligible women who are 30 years of age or older. Visit www.yctrust.net for resources and information.

The YCT Wellness Program is available to benefit eligible employees of the City of Prescott, Town of Chino Valley, Yavapai College, and Yavapai County, and, as well as their spouses and dependents.
Mid-Year Changes To Your Health Care Benefit Elections

IMPORTANT: After the open enrollment period is completed, (or if you are a new hire, after your initial enrollment election period is over), 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 Permitted Election Change Event as outlined below:

Special Enrollment Event:

- Loss of Other Coverage 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).
- Marriage, Birth, Adoption Event: 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.
- Medicaid/CHIP Event: You and your eligible dependents may also enroll in this plan if (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 Permitted Election Change 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, dependent’s death).
- Change in number or status of dependents (e.g. birth, adoption, dependent’s 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 Qualified Medical Child Support Order (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 election change 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 mid-year election change 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.

The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare and Medicaid (CMS) for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

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 certain events occur, and, as a result of the event, coverage of that qualified beneficiary ends (together, the event and the loss of coverage are called a qualifying event). Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events may 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 under the terms of the plan, if a loss of coverage results.

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 Marketplace coverage or for the tax credit. 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 must be sent to your 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.
Important Plan Information

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 Summary of Benefits and Coverage (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 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 has to follow about how the SBCs look, how many pages long the SBC should be, the font size, the colors used when printing the SBC and even which words are to be bold and underlined. A Uniform Glossary that defines many of the terms used in the SBC is available at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf.

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.

In December 2017 Congress passed a new law (the Tax Cuts and Jobs Act) that reduced the federal Individual Mandate penalty to zero starting in 2019. This means that starting in 2019 there will no longer be a federal Individual Mandate penalty for failure to maintain medical plan coverage.

If you choose to not be covered by a 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 an 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.

By law, you are NOT ELIGIBLE for HSA contributions if you:

- ✓ are enrolled in Medicare, such as Medicare Part A, B, C or D,
- ✓ are covered by another health care plan that is not an HDHP,
- ✓ can be claimed as a dependent on someone else’s tax return,
- ✓ are enrolled in a general Health Care Flexible Spending Account (or covered by a spouse’s FSA),
- ✓ are covered by a non-HDHP such as TRICARE and TRICARE For Life.

The plan administrator does not provide tax advice and no inference may be made that the information contained here constitutes tax advice. The tax information contained in this document is for general guidance only and is subject to change due to changes in IRS rules and regulations. You should consult a qualified tax advisor with regard to any questions you may have about the tax effects of an HSA on your individual circumstances.

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 on whether the prescription drug coverage under the medical plan options offered by YCT are or are not creditable, review the Plan’s Medicare Part D Notice of Creditable Coverage available online at www.yctrust.net.
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 800-847-7605.

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.

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by YCT. For more information, contact your HR Department.

IMPORTANT INFORMATION ABOUT THE YAVAPAI COMBINED TRUST WELLNESS PROGRAM
Our Yavapai Combined Trust (YCT) Wellness Program is voluntary and is designed to promote health or prevent disease. The term Wellness Program includes both:

a. ways that we help individuals identify and reduce health risk factors, like elevated blood pressure or excess weight, along with
b. ways to help individuals with chronic conditions, like diabetes, take better care of their condition, for example by working with a coach to encourage you to take the medication the doctor prescribes for your chronic condition.

The Wellness Program may offer incentives for participation. (such as for completing a Health Risk Appraisal questionnaire). All benefit eligible employees would have the opportunity to qualify for Wellness Program incentives if offered. If offered, incentives may be achieved at least once a year. The time commitment required to achieve incentives in our Wellness Program is reasonable. More information about our Wellness Program incentives is provided at www.yctwellness.com.

The Wellness Program incentives have been reviewed and in accordance with law, do not exceed 30% of the total cost of employee-only coverage under the plan (including employee & employer contributions).

Reasonable Alternative Standard: If you think you might be unable to meet a standard for a certain reward under our Wellness Program, you might qualify for an opportunity to earn the same reward by a different means. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the Wellness program, or if it is medically inadvisable for you to attempt to achieve the standards of the Wellness Program, then a reasonable alternative standard will be made available upon request. Contact Summit Administration Services for information on the Wellness Program and for information on reasonable alternative standards and accommodations.

We will work with you and, if you wish, your doctor, to find an alternative Wellness Program standard with the same reward that is right for you in light of your health status. If your personal doctor states that the alternative is not medically appropriate, a more accommodating alternative will be provided.

Contact Summit Administration Services for information on the wellness program and for information on reasonable alternative standards and accommodations. We will work with you and, if you wish, your doctor, to find a Wellness Program standard with the same reward that is right for you in light of your health status.
NOTICE REGARDING THE YCT WELLNESS PROGRAM
The Yavapai Combined Trust Wellness Program is a voluntary wellness program available to all benefits-eligible employees, their spouses and dependents and is designed to promote health or prevent disease. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the YCT Wellness Program, you may complete a Health Risk Assessment Survey or “HRA” that asks a series of questions about your health-related activities and behaviors. You may also complete an annual wellness exam that includes health screenings, such as pap, prostate, or mammogram screenings, blood work, yearly vision and/or hearing check, yearly dental check, and flu shot vaccination. You are not required to complete the HRA Survey, or participate in the blood test or other medical examinations.

However, those who choose to participate in the Wellness Program will receive a participation prize and be eligible for a grand prize, (details about the YCT Wellness Program incentives and prizes are explained on the YCT Wellness website at www.yctwellness.com). Although you are not required to complete the HRA or participate in the biometric screening, only those who do so will receive prizes.

Participants in the Go Fit Challenge must also sign up for and complete education and fitness components that involve attending classes and personal workouts. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Summit Administration Services at 800-690-2020.

The information from your HRA Survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the YCT Wellness Program. You also are encouraged to share your results or concerns with your own doctor.

Important Plan Information
Continued

Protections from Disclosure of Medical Information
Information collected from YCT Wellness Program participants will only be received by your employer in aggregate form. Although the YCT Wellness Program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, The YCT Wellness Program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

In addition, all medical information obtained through the YCT Wellness Program will be maintained separately from your personnel records and no information you provide as part of the YCT Wellness Program will be used in making any employment decision. Appropriate precautions will be taken by YCT and its Wellness Coordinator to avoid any data breach, and in the event a data breach occurs involving information you provided in connection with the YCT Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the YCT Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation related to the YCT Wellness Program, please contact Summit Administration Services at 800-690-2020.
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<td>Summit Administration Services, Inc.</td>
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<td>• COBRA Administration</td>
<td>Scottsdale, AZ  85255-0102</td>
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<td>American Health Group, Inc. (AHG)</td>
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<td>• Case Management Services</td>
<td>Mesa AZ  85210</td>
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<tr>
<td>• Medical Preferred Provider Network</td>
<td>602-265-3800 or 800-847-7605</td>
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<tr>
<td>(PPO Preferred In-Network Providers)</td>
<td><a href="http://www.americanhealthgroup.com">www.americanhealthgroup.com</a></td>
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<td>• Specialty Managed Drugs</td>
<td>Customer Service: 800-562-6223</td>
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<td>Clinical Prior Authorization: 800-711-4555 Option 1</td>
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<td>OptumRx Specialty Pharmacy: 866-218-5445</td>
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<td>Customer Service: 800-562-6223 (TTY: 800-735-2922)</td>
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