CITY OF PRESCOTT

YCT
Yavapai Combined Trust

YAVAPAI COUNTY

YAVAPAI COLLEGE
Be More

TOWN OF CHINO VALLEY, ARIZONA
Looking to the Future

YAVAPAI COMBINED TRUST

ANNUAL BENEFITS

2025 ENROLLMENT GUIDE

JULY 1ST - JUNE 30TH

Table Of Contents

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 Yavapai Combined Trust (YCT). This is your opportunity to elect the coverage appropriate for you and your eligible dependents. During Open Enrollment you can change, add, or drop coverage for you and your dependents. All changes will be effective from July 1 through June 30.

If you do not elect coverage, 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 22 of this Guide.

- You will also need to elect an HSA or FSA contribution each year if you wish to participate in a Health Savings Account or Flexible Spending Account.
- Newly benefits-eligible employees must enroll within 31 days of the date of hire or of becoming benefits-eligible.

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 2025/2026 YCT Plan Document 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. To find an in-network provider for medical, you can go online to summit-inc.net. For dental, visit Delta Dental at deltadentalaz.com/find. If you receive care that is determined to be medically unnecessary, it will not be covered by the Plan. Remember your healthcare is ultimately your responsibility, and we want you to get the care you need at the lowest cost to you.

YCT Yavapai Combined Trust

Enrolling for Benefits

Enrolling in Benefits

We recommend that you go online during Open Enrollment to review your benefits, confirm your enrollment, and make any changes. 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 24 for details about allowable changes to your elections.

When Can I Enroll?

- During the annual Open Enrollment period
- Within 30 days of experiencing a Special Enrollment Event or mid-year change in status
- Within 31 days of your initial benefit eligibility

Who Can Enroll?

- Benefits eligible employees
- An elected member of a Governing Body, while in office
- Your legal spouse
- Dependent child(ren), as defined in the YCT Plan Document

What Can I Enroll In?

- Medical
- Dental
- Vision
- Life Insurance
- Disability Insurance
- Flexible Spending Account
- Health and Wellness Benefits

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. By using the **Benefitfocus** Decision Making Tool, you can compare your medical plan options based on your personal medical claim history, then you can calculate your annual and monthly out-of-pocket cost for each plan. You will need to go to the **Benefitfocus** enrollment portal online to review your YCT benefits elections 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 enroll each year to participate. See pages 16 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 15 for more information.
7. Be sure to review and update the beneficiary information on the **Benefitfocus** enrollment portal, 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 complete your enrollment online 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 22.
10. Watch your mailbox for your Member ID Prescription Drug Cards within 14 business days of the date you enroll for coverage as a New Hire or if you make benefit changes during Open Enrollment.

Eligibility

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 your enrollment online within 31 days of your dependent becoming eligible for coverage or at Open Enrollment.

Dependent Children:

- Medical, Dental, and Vision plan benefits can be continued for a child up to the end of the month in which the child turns age 26.
- 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 22 for more information.

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".

Member ID/Prescription Drug Cards

Your Summit Member ID/Prescription Drug card shows network claims administration and verification information for medical, vision, and prescription drug coverage. If you enroll in dental you will get a separate card from Delta Dental. If you are enrolling for the first time, contact your HR Department if you do not receive your card(s) within 14 business days of the date you enroll for coverage.

Paying for Your Benefits

Each year, your employer contributes a certain amount to apply toward the cost of benefits. 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 Pretax Advantage

Most of your benefit premiums are deducted on a pretax basis, saving you federal, state, and Social Security taxes by reducing your taxable income. By having the pretax 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 16 for details regarding mid-year changes to your elections.

Information At Your Fingertips!

Visit **summit-inc.net** for access to information on Summit Administration Services, Inc., the prescription drug program, FSAs, precertification, and more.

YCT Yavapai Combined Trust

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 PPO 350 pays 80% in-network, and then you pay 20%; the PPO 600 Plan pays 60% in-network, and then you pay 40% (after you have met your deductible).

Annual Out-of-Pocket-Maximum: Your out-of-pocket maximum is the most you will pay within a given plan year. After your out-of-pocket maximum has been met, you are covered at 100%.

Preferred Provider: A healthcare 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 without a referral. To find an in-network provider, go online to summit-inc.net.

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

Medical Benefits

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.

Medical Coverage Options

You may waive coverage or choose from the following options:

PPO 350 Plan

You must meet the annual deductible ($350/person; $700/family) including copays for some services, and then most in-network expenses are paid at 80%. You will need to meet a separate out-of-network deductible for non-network providers and services, and then eligible expenses are covered at 60%.

PPO 600 Plan

You must meet the annual deductible ($600/person; $1,200/family) including copays for some services, and then most in-network expenses are paid at 60%. You will need to meet a separate out-of-network deductible for non-network providers and services, and then eligible expenses are covered at 50%.

HDHP Plan

Once you meet your annual deductible ($3,300/person; $6,600/family), 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 pretax contributions to pay for eligible healthcare expenses.

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 **summit-inc.net**.

Special Features of the HDHP 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 $3,300 individual or $6,600 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 healthcare 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: The HDHP has embedded deductibles.

When a health plan has embedded deductibles, it means that a single member of a family doesn't have to meet the full family deductible for after-deductible benefits to kick in. Instead, your after-deductible benefits will go into effect as soon as you have met the individual deductible, even if the coverage is through a family plan.

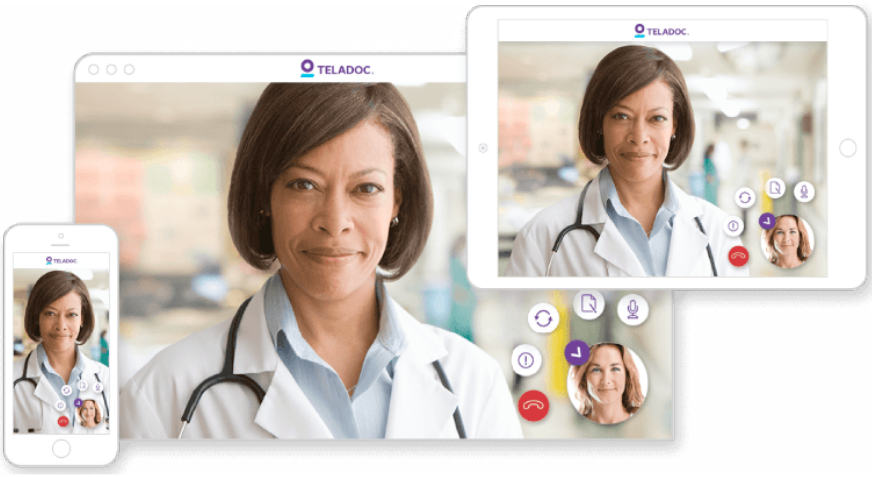
YCT Yavapai Combined Trust

Telehealth Benefits

Need to consult a doctor about a non-urgent illness or mental health issue but can't get an appointment with your primary doctor?

You can have your appointment through the convenience of phone or video consults. Whenever you feel unwell, it's an affordable, convenient, quality care alternative for treating cold and flu symptoms, bronchitis, respiratory infection, depression, anxiety, stress, and more!

If you are enrolled in the PPO 350 Plan or the PPO 600 Plan, there is no cost for using Teladoc. For those enrolled in the High Deductible Health Plan (HDHP), using Teladoc is $55 per consult (subject to a mid-year adjustment), and the cost is applied to your out-of-pocket limit.



What Kind of Doctors Will I Be Talking With?

Teladoc offers highly qualified, experienced doctors, therapists, and psychiatrists 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 are specially trained in treating patients through telehealth.

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.
- 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.

Consulting With a Teladoc Provider Is Easy as 1–2–3.

- **Register** – Log in to the Summit website at **summit-inc.net** and select Teladoc from Contacts and Links
- **Call** – **800-362-2667**
- **Online** – Request a video consultation online at **teladoc.com**
- **On the go** – You can download the Teladoc mobile app by visiting the App Store or Google Play

The Medical Plans

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.

You can choose to use any provider in or out-of-network, however, your plan benefits will be the greatest when using an in-network provider.

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.

Medical Plan Highlights and Comparison

Benefit Description	PPO 350 Plan	
	In-Network[1]	Out-of-Network[3]
Plan Year Deductible (July 1– June 30) (deductible applies to most charges unless otherwise specified)	$350/person; $700/family	$350/person; $700/family
	The ded. for in-network providers does not accumulate to meet the ded. for out-of-network providers and vice versa	
Out-of-Pocket Limit (July 1– June 30) (includes deductibles, copayments, and coinsurance)	$3,350/person; $6,700/family In-network covered service plus in-network outpatient drugs accumulate to the in-network out-of-pocket limit	No out-of-pocket maximum
Emergency Room	You pay a $150 copay/visit, then ded., then the plan pays 80% and you pay 20%	
Urgent Care	$50 copay/visit (ded. waived)	60%
Hospital (inpatient/outpatient)	The plan pays 80%, you pay 20%	60%
Primary Care Physician (PCP) • Office visits • Teladoc online services • Specialist	$20 copay/visit (ded. waived) No cost (ded. waived) $35 copay/visit (ded. waived)	60% Not covered 60%
Maternity Services Pre/Postnatal mandated services All other services	100% (ded. waived) $150 copay then you pay 20%	After you pay a $150 copay, the plan pays 60%
Lab (non-hospital)	100% (ded. waived)	60%
Alternative Healthcare Services (acupuncture, naturopathic, and/or chiropractic services have a yearly benefit limit)	The plan pays 80%, you pay 20%	60%
EAP	Up to 6 free visits per plan year with an EAP counselor per problem per person, by calling 888-520-5400	
Behavioral Health/Substance Abuse • Outpatient • Inpatient	$20 copay/visit (ded. waived) The plan pays 80%, you pay 20%	60% 60%
Wellness – Birth to 18 years (deductible waived)	100%	100% after $20 copay/visit
Wellness – 18 years & older	Plan pays 100% (ded. waived) Routine wellness-related blood/lab tests covered at 100% in-network	
Recommended Immunizations	100% (ded. waived)	100% (ded. waived)
Retail In-Network Pharmacy[2] Tier 1 - Generic Tier 2 - Preferred Brand Tier 3 - Non-preferred Brand	**Up to a 30-day supply** (ded. does not apply) $10 copay 20% of drug cost, $100 copay max. 50% of drug cost, $20 copay min. $150 copay max.	**Up to a 90-day supply** (ded. does not apply) $30 copay 20% of drug cost, $300 copay max. 50% of drug cost, $60 copay min. $450 copay max.
Mail Order In-Network Only Tier 1 - Generic Tier 2 - Preferred Brand Tier 3 - Non-preferred Brand	**Up to a 90-day supply** (ded. does not apply) $15 copay $40 copay $100 copay	

[1]Percentage paid is based on the PPO Allowance. Deductible applies to all benefits except where otherwise specified.
[2]Formulary-listed drugs only. If the drug cost is less than the copay, you pay the cost of the drug.
[3]Plan pays up to the allowed charges after the deductible has been met. You may be responsible for the difference between the billed charges and the amount this Plan allows. Deductible applies to all benefits except where otherwise specified.

YCT Yavapai Combined Trust

The Medical Plans (continued)

Medical Plan Highlights and Comparison

PPO 600 Plan		HDHP Plan	
In-Network[1]	**Out-of-Network[3]**	**In-Network[1]**	**Out-of-Network[3]**
$6000/person; $1,200/family	$1,200/person; $2,400/family	$3,300/person; $6,600/family	
The ded. for in-network providers does not accumulate to meet the ded. for out-of-network providers and vice versa			
$6,600/person; $13,200/family In-network covered services plus in-network outpatient drugs accumulate to the in-network out-of-pocket limit	No out-of-pocket maximum	$3,300/person; $6,600/family	$10,000/person; $20,000/family
You pay a $150 copay/visit, then ded., then the plan pays 60% and you pay 40%		100% after ded.	
$60 copay/visit (ded. waived)	50%	100% after ded.	50% of the allowed charge after ded.
The plan pays 60% and you pay 40%	50%	100% after ded.	50% of the allowed charge after ded.
$30 copay/visit (ded. waived) No cost (ded. waived) $45 copay/visit (ded. waived)	50% Not Covered 50%	100% after ded. $55 copay 100% after ded.	50% of the allowed charge after ded.
100% (ded. waived) $150 copay then you pay 40%	After you pay a $150 copay, the plan pays 50%	100% (ded. waived) Other services covered 100% after ded.	50% of the allowed charge after ded.
100% (ded. waived)	50%	100% after ded.	50% of the allowed charge after ded.
The plan pays 60% and you pay 40%	50%	100% after ded.	50% of the allowed charge after ded.
Up to 6 free visits per plan year with an EAP counselor per problem per person, by calling 888-520-5400		Up to 6 free visits per plan year with an EAP counselor per problem per person, by calling 888-520-5400	
The plan pays 60% and you pay 40% The plan pays 60% and you pay 40%	50% 50%	100% after ded.	50% of the allowed charge after ded.
100%	50%	100% (ded. waived)	50% of the allowed charge after ded.
Plan pays 100% (ded. waived) Routine wellness-related blood/lab tests covered at 100% in-network		100% (ded. waived)	50% of the allowed charge after ded.
100% (ded. waived)	100% (ded. waived)	100% (ded. waived)	50% of the allowed charge after ded.
Up to a 30-day supply (ded. does not apply) $10 copay 20% of drug cost, $100 copay max. 50% of drug cost, $20 copay min. $150 copay max.	**Up to a 90-day supply** (ded. does not apply) $30 copay 20% of drug cost, $300 copay max. 50% of drug cost, $60 copay min. $450 copay max.	100% after ded. + Expanded Preventive Drug Medications	50% of the allowed charge after ded.
Up to a 90-day supply (ded. does not apply) $15 copay $40 copay $100 copay		100% after ded. + Expanded Preventive Drug Medications	50% of the allowed charge after ded.

[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.

YCT
Yavapai Combined Trust

Prescription Drug Coverage

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.

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 elect 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 summit-inc.net and click Contacts and Links, or go to OptumRx.com and sign in.

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. Call 800-562-6223 for more information.

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.

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 whether or not it is covered by your prescription plan.

Prescription Drug Tiers

Tier 1

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.

Tier 2

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.

Tier 3

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).

Prescription Drug Coverage (continued)

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 BriovaRx, the OptumRx Specialty Pharmacy at 855-427-4682, fax to 877-342-4596, or log on to 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 summit-inc.net and click Contacts and Links and then on Prescription Coverage. From there you can access the OptumRx.com website.

- **Copay and Drug Information** – Compare copays at specific pharmacies or the Mail Service Pharmacy service so you can 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** – These include, but are not limited to, Safeway, Fry's, Walmart, CVS, and Walgreens.

For the HDHP your pharmacy benefit plan includes Expanded Preventive Drug Medications. These medications help protect against or manage medical conditions. The drugs on your plan's preventive medications list do not have a deductible. This means you'll pay your copayment/coinsurance or nothing at all.

What Pharmacies Can I Use?

You can find a participating pharmacy online. Visit **summit-inc.net** and click Contacts and Links to access **OptumRx.com**.

Where Can I Find The OptumRx Formulary?

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

How Long Does It Take To Get A Prescription Through The Mail Service Pharmacy?

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

The Dental Plans

The Trust partners with Delta Dental and utilizes the Delta Dental PPO & Premier Networks.

The Delta Dental Network has the largest network of dentists nationwide. The Delta Dental PPO Network provides the lowest out-of-pocket costs. That's because PPO Network dentists agree to accept lower reimbursements for services.

The Delta Dental Premier Network provides a wider selection of dentists while keeping out-of-pocket costs economical. You may visit any network dentist, but you will save the most money by visiting a PPO dentist. To find an in-network dentist go to deltadentalaz.com/find.

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. You can cover your child(ren) on both dental plans up to age 26.

The Comprehensive Plan & The Basic Plan both cover Preventive services at 100%, with no deductible. The differences between the plan options are the annual maximum, the percentage of coverage for Basic and Major Services, and the cost of the benefits. The Basic Plan has in-network coverage only. The Comprehensive Plan includes orthodontia and also has a maximum rollover feature which allows you and your dependents to rollover a portion of your unused annual Dental plan maximum when you get two preventive cleanings a year. For more detailed information, see your YCT Plan Document.

YCT Yavapai Combined Trust

The Dental Plans (continued)

Dental Plan Benefits Highlights and Comparison		
Network	**PPO & Premier Network**	
	In-Network & Out-of-Network	**In-Network Only**
Benefit Description	**Comprehensive Plan[1]**	**Basic Plan**
Annual Deductible (July 1-June 30)	$50 / $150	$50 / $150
Annual Maximum (July 1-June 30)	$2,000 ($500 rollover to max of $4,000)	$1,000
Preventive Services (subject to annual dental maximum)	100%	100%
Basic Services (includes fillings, extracts, oral surgery)	90% after ded.	70% after ded.
Major Services (includes onlays, crowns, dentures)	60% after ded.	40% after ded.
Orthodontic Services (Adult & Child)	50% up to $1,500 Lifetime Maximum	N/A

[1]For the Comprehensive Plan if you choose to receive the services from an out-of-network dentist, you will have to pay the difference between the dentist's charges and the Plan's allowable fee in addition to the normal plan costs.

The Vision Plan

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

The Trust partners with Summit to provide vision benefits, offering a $500 per plan-year benefit per person. This benefit can be used for eligible expenses, including vision exams, lenses and frames, prescription sunglasses, and contact lenses. Additionally, there is an embedded $200 maximum for certified safety glasses.

To receive vision care, simply visit any optometrist, ophthalmologist, or optician and provide your insurance card. There no claim form needed, to submit your claim provide your invoice and receipt directly to Summit. Vision coverage can be extended to your child(ren) up to the age of 26. For further details, please consult your YCT Plan Document.

Life Insurance

Basic Life Insurance

Basic life insurance coverage is automatically provided to all eligible employees on the first day of employment or on the date you become benefits-eligible with a participating employer. Employees aged 65 to 69 will receive 65% of the benefit and employees aged 70+ will receive 50% of the benefit.

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 $2,000 for your spouse and $1,000 for each dependent child.

For more information, contact your HR Department. These Lifestyle Benefits are automatically available to active employees insured with Securian Financial.

Legal, Financial, and Grief Resources

Professional services for a variety of needs – from legal matters and financial situations to coping with loss – through comprehensive web and mobile resources, as well as consultations. Access these resources by logging onto **LifeBenefits.com/Lfg** or calling **877-849-6034**.

Username: lfg | Password: resources

Travel Assistance

24/7 online, pre-trip resources and support for emergency travel assistance, and other services when traveling 50+ miles from home. Visit **LifeBenefits.com/travel** or call **855-516-5433** when in the US or Canada or **+1-415-484-4677** from all other locations.

Legacy Planning Resources

Online information and resources to help with multiple aspects of legacy planning – from end-of-life and funeral planning, final arrangements, directives, and survivor assistance. Visit **securian.com/legacy** for details.

Beneficiary Financial Coaching

Dedicated financial coaching: Available monthly via phone for help with financial decisions during first 6 months after claim is paid. Includes coaching the following 6 months, as needed. Access to PwC Envision™: 12 months of mobile-enabled web application with budgeting, planning tools, and content. Financial fitness assessment: Personalized wellness report outlines key action items to discuss with a financial coach. Survivor guide workbooks: Help make financial and legal decisions less overwhelming. Beneficiaries receiving $25,000 or more will be invited to take advantage of this program when the life insurance claim is paid. Telephone financial guidance is provided to beneficiaries receiving $100,000+.

We know that loss is inevitable - but when it happens, many of us are unprepared for the emotional and practical challenges it may bring. That's why we provide Empathy, a bereavement support service that helps beneficiaries get back on their feet following the loss of a loved one. visit **join.empathy.com/securian** for more information.

Life Insurance (continued)

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

Voluntary Life Insurance

In addition to your employer-paid life insurance, you have the option to purchase voluntary life insurance. You can purchase coverage for yourself, your spouse, and your dependent child(ren). To enroll, complete the voluntary life insurance Enrollment Form in Benefitfocus.

Coverage Options

Eligible employees may elect voluntary life insurance coverage in increments of $10,000, to a maximum of $750,000. For your spouse, you may elect voluntary life insurance up to 100% of your total employee basic plus voluntary coverages combined in $5,000 increments, up to a maximum of $250,000. You may also elect one of 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, $20,000. If you don't enroll when you're first eligible, you may be required to provide evidence of insurability.

Voluntary Life Insurance Rates

Voluntary life insurance rates for you and your spouse are based on age. The rates are listed in the voluntary life insurance section of Benefitfocus. Premiums for voluntary life insurance benefits are set up through payroll deductions on an after-tax basis.

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 are eligible for this coverage for the first time
- You are electing the guarantee issue of $300,000 for employee, $50,000 for spouse coverage, or $20,000 per child

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

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

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. Refer to HR about how to apply.

Flexible Spending Accounts (FSAs)

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

If you want to participate in a Flexible Spending Account (FSA), you must enroll each year. To participate in an FSA for the 2025-2026 plan year, you must indicate your contributions for the 12-month period when you enroll. You cannot change your elections mid-year unless you have a Special Enrollment Event.

Manage Your FSA Online

1. To log into your Flexible Spending Account and access your FSA information, visit: summitmember.Lh1ondemand.com

2. Your first login has a pre-assigned user name and password. You will use the first initial of your first name, full last name, and the last four 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.

When you log into your account, you can view and print transaction activity, view the balance in your FSA account, and edit your profile, including your password or email address. To order a $10 replacement FSA Benefit Card, please contact Summit Administration Services, Inc., at 888-690-2020.

Highlights of the Flexible Spending Account Program

- The plan year for the Flexible Spending Accounts is July 1, 2025, through June 30, 2026.
- You choose the annual amount to contribute, which is deducted from your check before taxes are taken out, lowering your taxable income.
- The maximum amount you can deposit each plan year to an FSA:

  Healthcare – $3,300 ($3,000 for City of Prescott) 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.
- Pretax funds are deposited into your Healthcare and/or Dependent Care account via payroll deduction. If you elect to contribute to the Healthcare FSA, your total annual contribution is available to use at the 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 Benefit Card in the mail to use as long as your FSA is active. You can use this card to pay for qualified purchases at many merchants and service providers, or you can mail in a claim form for reimbursement.
- Unused amounts do not carry over to the next plan year.

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 make 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 Healthcare FSA, contact your HR Department.

YCT Yavapai Combined Trust

Flexible Spending Accounts (FSAs)(continued)

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, 2026 for eligible expenses incurred during the plan year between July 1, 2025 and June 30, 2026. 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. It is recommended you keep ALL receipts for all FSA-eligible expenses.

Healthcare 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 healthcare expenses that are not covered by your insurance.

- For a general purpose Healthcare FSA, eligible healthcare 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.

Over the counter medicines or drugs are fully eligible with no restrictions.

- For a limited purpose Healthcare FSA, eligible healthcare 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 that 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 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 ID number of the day care provider on submitted claims.

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

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

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

Health Savings Account

A Health Savings Account (HSA) Is Available Only When You Enroll in the HDHP

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

Enrolling In A Health Savings Account

You will need to complete your enrollment online in order to establish your account. This account can help you pay for eligible healthcare expenses for you and your family. The account is managed by HealthEquity 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 2025-2026, if you are an active employee, you may contribute up to $4,300 for individual coverage and $8,550 for family coverage on a pretax 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 pretax 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 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. Any money in your HSA will automatically rollover 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. At retirement, you can also use the money to help pay for retiree health expenses. For more information, call the HSA administrator, HealthEquity, at **866-346-5800**, or visit **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
- Cannot be claimed as a dependent on someone else's tax return

YCT Yavapai Combined Trust

Health Savings Account (continued)

Eligible Healthcare Expenses

An HSA can help you pay for certain healthcare expenses that are not otherwise covered by the Plan, including costs toward your annual deductible. In general, eligible healthcare 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.

Examples of Eligible Healthcare Expenses 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
- 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 **irs.gov** and review Publication 502. If you still have questions, contact a Member Services specialist by calling HealthEquity at **866-346-5800** anytime, day or night.

If you pay expenses through your HSA, you have already used pretax 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.

Additional Benefits

Employee Assistance Program (EAP)

At some point in our lives, each of us faces a problem or situation that is difficult to resolve. When these instances arise, SupportLinc will be there to help. SupportLinc is a confidential resource that helps you deal with life's challenges and the demands that come with balancing home and work. The program provides professional counseling and expert referrals for a wide array of personal and work-related concerns.

SupportLinc is provided by CuraLinc Healthcare.

CuraLinc has redefined the modern employee assistance program (EAP) by looking at mental health through a more human-centric lens, empowering meaningful treatment by facilitating personalized access to care through a system of integrated in-person and digital modalities.

Calm Subscription

Millions of people are experiencing lower stress, less anxiety, improved focus, and more restful sleep with Calm. Whether you have 30 seconds or 30 minutes, Calm content is made to suit your schedule and needs.

To activate your subscription you'll need your unique entity's QR code or website:

- Sign in to your existing Calm account or create an account. This must be done on a web or mobile browser (not in the app itself).
- Enter your entity email address in the box provided to activate the subscription on your Calm account
- Download the Calm app and log in to your account to access the premium content
- Once you've signed up, you can add up to 5 dependents (age 16 years or older) via the "Manage Subscription" page inside your Calm account at calm.com

Need help? Reach out to the support.calm.com with any questions.

The Hines Case Management program helps members who may be experiencing a potentially serious health condition. You'll receive the services of an experienced Registered Nurse who understands your health condition, needs, and concerns. The goal is to help you understand your health condition, to be involved in your care, and to assist with the coordination of your treatment. For help with precertification, call **800-592-8097**.

Hinge Health

Hinge Health offers FREE care for your back and joints. Recover from a recent or past injury. Prepare for surgery. Overcome back and joint pain. Stay healthy and pain free. Get the tools to move freely again and do it from the comfort of your home, on your schedule.

Get virtual care based on your situation:

- A personal care team, including a physical therapist and health coach
- 1-on-1 physical therapy sessions
- A second opinion on surgery or treatment plan

To learn more call 855-902-2777 or visit hingehealth.com/yavapaicombinedtrust

YCT Yavapai Combined Trust

Additional Benefits (continued)

Tria Health

Tria Health provides one-on-one, confidential consultations over the phone with a certified coach and pharmacist. Your personal Tria Health consultant will work with you and your doctor(s) to make sure your health is properly managed through your medications. This is available to all members enrolled in one of YCT's medical plans.

Tria Health is recommended for members who have any of the following conditions:

- Diabetes
- Heart disease
- High cholesterol
- High blood pressure
- Mental health
- Asthma/COPD
- Osteoporosis
- Migranes
- Pain
- Specialty medications

You can enroll in Tria Health by calling **888-799-8742**, or visiting Tria's enrollment site at **triahealth.com/enroll**.

Your Tria Health pharmacist can help you save money by identifying savings opportunities within your current medication regimen. Active participants who complete a consultation with a Tria Health pharmacist can receive free generic medications and discounted brand medications used to treat certain chronic conditions. Participants with diabetes will also have free access to a wireless blood glucose meter, testing strips, and supplies.

Active & Fit

Active & Fit is a flexible and affordable membership program designed to let you workout your way. Registered members can get 12,000+ on-demand workout videos for free or enroll in the full program to choose from thousands of gyms, boutique studios, Lifestyle coaching, and more. Visit your employee portal to enroll.

Choose To Lose Program

Choose to Lose is a personalized weight management program that connects you with a dedicated health coach. Using the Tria Health app, you'll easily track your meals and collaborate with your coach to create a customized plan, setting you up for lasting success.
Program Requirements:

- BMI of 30.0+ or BMI between 27.0-30.0 with 1 chronic condition

To enroll, visit triahealth.com/ctl-yct

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 events such as on-site mammography, on-site prostate exams, flu shot, well baby exams, and health screening clinics are offered through the Wellness Program at no cost to employees and their dependents. For more information visit Benefitfocus.

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

Important Plan Information

This document contains important employee benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year. Be sure you are reviewing an updated version of this important notices document.

Mid-Year Changes To Your Healthcare 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 you (or your dependents):

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

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

Mid-Year Permitted Election Change Event:

Because the Trust pretaxes 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).
- 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 midyear 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: 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 Healthcare Marketplace. See 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 (continued)

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 dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for your medical plan options, go to **Benefitfocus** or contact your HR Department.

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 healthcare plan that is not an HDHP,
- ✓ can be claimed as a dependent on someone else's tax return,
- ✓ are enrolled in a general Healthcare 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. **The Claims Administrator** Summit Administration Services, Inc., is responsible for processing all the claims for medical, vision and short-term disability; providing verification of benefits and eligibility, as well as administering the FSA Plan and COBRA. Contact Summit Administration Services, Inc. by calling 888-690-2020 or access their website at summit-inc.net.

The Claims Administrator Delta Dental is responsible for processing all of the claims for dental, providing verification of benefits and eligibility. Contact Delta Dental by calling 602-938-3131 or 800-352-6132 or access their website at deltadentalaz.com.

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 healthcare provider; however, payment by the Plan may be less for the use of an out-of-network provider.

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 PPO 350 Plan, the PPO 600 Plan, or the HDHP 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.

Important Plan Information (continued)

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 healthcare professional who specializes in obstetrics or gynecology. The healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, go online to summit-inc.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 Benefits Team.

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
- 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.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or

CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states (As of March 17, 2025) you may be eligible for assistance paying your employer health plan premiums. (AL, AK, AR, CA, CO, FL, GA, IN, IA, KS, KY, LA, ME, MA, MI, MN, MT, NE, NV, NH, NJ, NY, NC, ND, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, WV, WI, WY). To see if any other states have added a premium assistance or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

YCT Yavapai Combined Trust

Important Plan Information (continued)

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. Although you are not required to complete the HRA or participate in the biometric screening, only those who do so will receive prizes.

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.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Wellness Program and YCT may use aggregate information it collects to design a program based on identified health risks in the workplace, 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 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.

Contact Information

If You Need More Information About…	Contact…
• Medical and Vision Claims • Eligibility • COBRA Administration • HIPAA Certificate of Coverage • Short-Term Disability (for employees of participating employers of the Trust) • FSA Administration	Summit Administration Services, Inc. P.O. Box 25160 Scottsdale, AZ 85255-0102 888-690-2020 or 480-505-0400 M – TH 8:00 a.m. – 5:00 p.m. F 8:00 a.m. – 4:30 p.m. Fax: 480-505-0407 **summit-inc.net**
• Utilization Management Program • Precertification of Medical/Surgical Services • Medical Review Services • Case Management Services	Hines 115 East Highland Ave. Elgin, IL 60120 800-592-8097 **hinesassoc.com**
• Medical Preferred Provider Network (PPO Preferred In-Network Providers) • Network Behavioral Health Providers	Blue Cross Blue Shield of Arizona (BCBSAZ) **azblue.com** Blue Preferred PPO Network
• Dental Network (PPO & Premier In-Network Providers) • Dental Claims • Dental Eligibility	Delta Dental **deltadentalaz.com/member** 602-938-3131 or 800-352-6132 PPO & Premier In-Network
• Health Savings Account Administration	HealthEquity Member Services: 866-346-5800 **healthequity.com**
• Employee Assistance Program (EAP)	SupportLinc/CuraLinc 800-881-5462
• Retail/Mail Order Prescription Drug Program • Retail Network Pharmacies • Prescription Drug Information and Formulary • Prior Authorization of Drugs • Specialty Managed Drugs	**OptumRx** Customer Service: 800-562-6223 Clinical Prior Authorization: 800-711-4555 Option 1 OptumRx Specialty Pharmacy: 866-218-5445 **Home Delivery Mail Service** Customer Service: 800-562-6223 (TTY: 800-735-2922) **summit-inc.net** or **OptumRx.com**
• Yavapai Combined Trust (YCT)	Plan Administrator: Wendy Ross Phone: 928-771-3252 Fax: 928-771-3419
• Yavapai College	Human Resources Department 1100 E. Sheldon Prescott, AZ 86301 Phone: 928-776-2217 Fax: 928-776-2202 **AskHR@yc.edu**
• City of Prescott	Human Resources 201 N. Montezuma Street, Suite 207 Prescott, AZ 86301 Phone: 928-777-1410 Fax: 928-777-1213
• Yavapai County	Human Resources 1015 Fair Street, Rm. 338 Prescott, AZ 86305 Phone: 928-771-3252 Fax: 928-771-3419
• Town of Chino Valley	Human Resources Department 202 N. State Route 89 Chino Valley, AZ 86323 Phone: 928-636-2646 Fax: 928-636-9129

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.

To find more detailed information follow the instructions below for your entity.

City of Prescott - Click on the benefits tab at the top of the employee portal or visit benefits.prescott-az.gov from any computer

Town of Chino Valley - Go to secure-enroll.com/go/chinoaz

Yavapai College - Go to "My Benefits"

Yavapai County - Go to: secure-enroll.com/sso/saml/yavapaicounty/member

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.

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