

# Town of Paradise Valley

2016 – 2017 OPEN ENROLLMENT GUIDE



## *The Town of Paradise Valley's annual Open Enrollment period is here!*

*May 18-29, is your open enrollment window of opportunity to review and make changes to your benefits for the coming plan year. Take the time to carefully read through this Guide with your family and elect the benefits that will go into effect July 1, 2016.*

*All the Town's benefits are remaining the same. All employees will need to complete a form to enroll in the Health Savings Account (HSA).*

## **Get Ready to Enroll**

If you want to make changes to your benefit elections, you will need to complete and submit your enrollment form(s):

- Select a medical program option. To decline coverage, you must complete the portion of the enrollment form that indicates your desire to opt out of coverage through APEHP.
- Decide on the tier of coverage you want, depending on who will be covered. If you are adding a lawfully married spouse, you will need to provide a certified marriage certificate. If you are adding a domestic partner, complete the statement of domestic partnership.

Your choices for coverage are:

- employee;
- employee plus spouse or domestic partner;
- employee plus child(ren); or
- employee plus family.

- If you wish to contribute to the Health Savings Account (HSA), you need to decide how much you will contribute. Please note that you are not required to contribute to the HSA\*.
- Fill out the VSP enrollment form if you want to add or delete vision coverage.
- Confirm that any dependents are still eligible to be enrolled.
- Sign and date the enrollment form(s).

\* You will need to complete an additional form for the HSA, which will be provided during your open enrollment meeting, and is also available from Human Resources.

If you have questions about eligibility, please contact your Human Resources Department or refer to the Plan Document/Summary Plan Description (SPD).

***Benefits go into effect July 1, 2016.***

***If you have any questions or need more details on any of the Town's benefits, please contact Jinnett Hancock at 480-348-3520 or Jennifer Gabriel of APEHP at 602-222-2113.***

# OPEN ENROLLMENT BASICS

## Who's Eligible to Enroll?

Those eligible for the Town of Paradise Valley's benefits include:

- Employees working at least 30 hours per week. The waiting period for new employees is the first day of the month following 30 days of employment.
- Dependents of enrolled employees, including:
  1. lawfully married spouse;
  2. domestic partner; and
  3. dependent children up to age 26

**NOTE:** If your spouse loses coverage – due to a job loss, for example – that is considered a qualifying event. He or she may enroll in APEHP within 31 days of the event.

## What Happens if You Don't Enroll

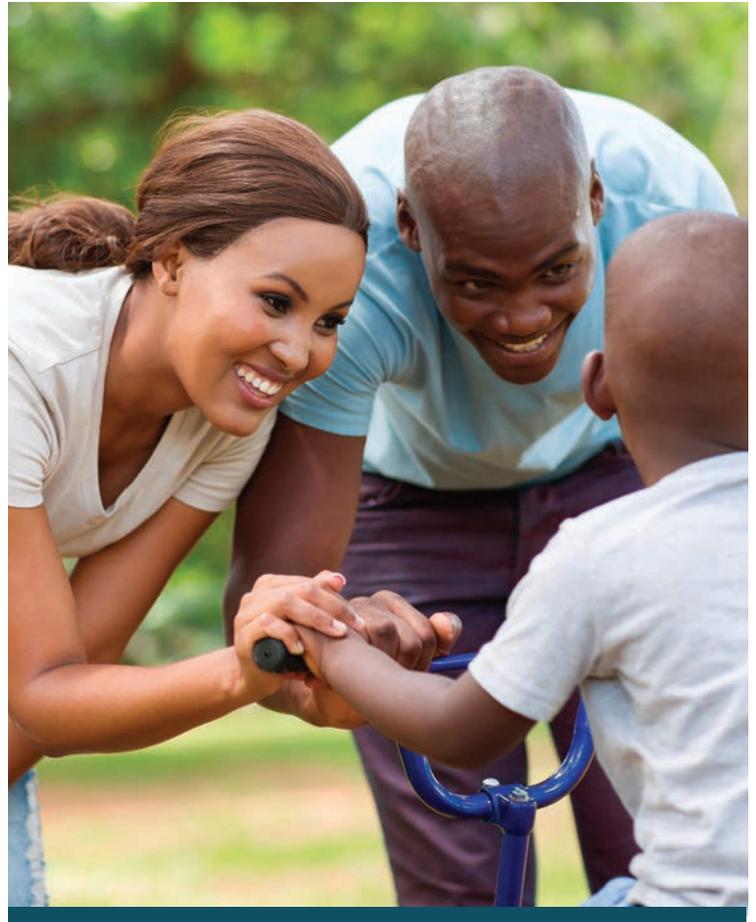
Open enrollment is the one time each year when you can make changes to your benefit elections.

If you don't complete and return an enrollment form during this year's open enrollment, you will continue to have the same benefits as the 2015-2016 plan year, and you will have to wait to enroll until the next open enrollment unless you experience a mid-year change in status event (see Mid-Year Changes).

## How to Enroll in a Health Savings Account (HSA)

If you are enrolling for the first time, you will need to complete an additional enrollment form to establish your HSA and choose the amount you wish to contribute to your HSA using pre-tax dollars. ***If you are currently contributing to an HSA, you will need to complete a new form to confirm your 2016-2017 contribution.*** Your contribution combined with the Town's contribution must not exceed the IRS limits. See the HSA section for more information on contributions. You must be HSA-eligible in order to establish an HSA. Check with your HR Manager or attend an open enrollment meeting for more information.

Once you establish your HSA, you can use your HSA debit card to pay for qualified expenses for you and any dependents you claim on your tax return. Remember, you can only withdraw funds after they are deposited into your HSA.



## Helpful Tips:

- Dependent children up to age 26 can be covered under a parent's plan, regardless of student or marital status.
- Participants cannot be covered by more than one APEHP employer's plan for any medical, dental, vision, or life insurance benefits.
- If you are expecting a baby and want APEHP coverage for your child, please remember to complete the appropriate forms within 31 days following the birth.

**Forms are due to  
Human Resources by  
May 29, 2016.**

## What's New for 2016-2017?

There are changes being implemented for the Plan Year starting July 1, 2016. Here is a brief summary of those changes. Refer to the specific sections of this guide that pertain to these subjects for more information.

- **Identification cards.** This year new identification cards will be issued for medical and prescription drug coverage prior to the new plan year. Please do not destroy your current ID cards until you have received a new set.
- The high deductible health plan out-of-pocket limit will decrease from \$6,900 to \$6,550 for a family of 2 or more (in-network).
- Now offering two medical plan options – the **Copay Plan** and the **\$2,500 HDHP with HSA**.
- Health Savings Account (HSA) contributions will increase. The HSA maximum allowable contributions for the 2016–2017 plan year are \$3,350 for individual coverage and \$6,750 for family coverage .
- CVS/Caremark will be the new pharmacy benefit manager. Participants that utilize the mail order program, will need a new prescription from their providers to transfer to the Caremark Mail Service Pharmacy even if the current prescription has not expired.
- Participants should fill their prescription prior to the start of the new year.
- Participant's receiving physical, occupation, or speech therapy will no longer have to obtain a prescription for claims to process.
- **Preauthorization requirements for some medications.** Preauthorization will be required for compound and unit cost drugs costing more than \$300. Individuals *currently* receiving a compound or unit cost prescription through the plan are exempt from this requirement.
- **Medication Therapy Management.** This will be required for certain individuals, to be determined by the plan.



### Attend an Enrollment Meeting for More Information

*May 18th*

10:00 AM – 11:30 AM — Town Hall Community Room

A Representative from APEHP will be onsite to present the meetings.  
Please feel free to invite your spouse to attend.

# RATE SHEET: 2016-2017

## Medical Plan Premiums

<b>\$2,500 HDHP</b>	<b>Total Premium (Monthly)</b>	<b>Town Pays (Monthly)</b>	<b>Employee Pays (Monthly)</b>	<b>Employee Pays (Per Pay Period)</b>	<b>Increase (Per Pay Period)</b>
Employee Only	\$466.00	\$466.00	\$0.00	\$0.00	\$0.00
Employee + Child(ren)	\$772.00	\$695.50	\$76.50	\$38.25	\$1.75
Employee + Spouse	\$931.00	\$814.75	\$116.25	\$58.13	\$2.88
Employee + Family	\$1,178.00	\$1,000.00	\$178.00	\$89.00	\$4.13

<b>Copay</b>	<b>Total Premium (Monthly)</b>	<b>Town Pays (Monthly)</b>	<b>Employee Pays (Monthly)</b>	<b>Employee Pays (Per Pay Period)</b>	<b>Increase (Per Pay Period)</b>
Employee Only	\$707.00	\$707.00	\$0.00	\$0.00	\$0.00
Employee + Child(ren)	\$1,172.00	\$1,055.75	\$116.25	\$58.13	\$2.76
Employee + Spouse	\$1,412.00	\$1,235.75	\$176.25	\$88.13	\$4.13
Employee + Family	\$1,785.00	\$1,515.50	\$269.50	\$134.75	\$6.38

## Health Savings Account (HSA)

<b>Health Savings Account (HSA) HDHP PLAN PARTICIPANTS ONLY</b>	<b>Annual Town Contribution</b>	<b>Town Per Pay Period Contribution (26 Annually)</b>	<b>Annual Max Employee Contribution After Town Contribution</b>	<b>IRS Annual Max (Calendar Year 2016)</b>
Employee Only	\$2,600	\$100	\$750	\$3,350
Employee + Dependent(s)	\$4,420	\$170	\$2,330	\$6,750

## Dental Plan Premiums

<b>Delta Dental PPO</b>	<b>Total Premium (Monthly)</b>	<b>Town Pays (Monthly)</b>	<b>Employee Pays (Monthly)</b>	<b>Employee Pays (Per Pay Period)</b>	<b>Increase (Per Pay Period)</b>
Employee Only	\$36.20	\$36.20	\$0.00	\$0.00	\$0.00
Employee + Family	\$104.05	\$87.09	\$16.96	\$8.48	\$0.30

## Voluntary Vision Plan Premiums

<b>VSP Plan 1</b>	<b>Employee Pays (Monthly)</b>	<b>Employee Pays (Per Pay Period)</b>	<b>VSP Plan 2</b>	<b>Employee Pays (Monthly)</b>	<b>Employee Pays (Per Pay Period)</b>
Employee Only	\$9.69	\$4.85	Employee Only	\$5.64	\$2.82
Employee + Dependent	\$15.50	\$7.75	Employee + Dependent	\$9.03	\$4.52
Employee + Child(ren)	\$15.83	\$7.92	Employee + Child(ren)	\$9.21	\$4.61
Employee + Family	\$25.52	\$12.76	Employee + Family	\$14.86	\$7.43

# MEDICAL PLAN HIGHLIGHTS

## How the Medical Plan Works

The medical plan has a PPO network that utilizes the BlueCross BlueShield of Arizona (BCBSAZ) network or the Mayo Clinic. You can see any provider, however you can take advantage of lower out-of-pocket costs by using BCBSAZ network providers. You can find up-to-date BCBSAZ provider directories on their website, [www.azblue.com](http://www.azblue.com). A few of the highlights are shown on the following pages.

## Your Annual Deductible

The annual deductible is the amount of covered medical expenses that you pay each fiscal year (from July to June) before the plan pays any benefits. Once you meet the deductible, you pay a percentage of covered medical costs (coinsurance), and the plan pays the rest. You must first meet a separate deductible for both in-network and out-of-network services before the plan will pay benefits. Once your coinsurance reaches the out-of-pocket maximum for either the in-network or out-of-network services for the fiscal year, the plan pays 100% of the remaining allowed charges for the rest of the plan year. You should not be required to pay anything out of pocket at the point of service.

## In-Network versus Out-of-Network Services

You can use any qualified provider you choose, however, your benefits will be greater if you use in-network providers and facilities. To find an in-network provider, visit the APEHP website at <http://www.apehp.org> and click on Employee Resources. When you use an in-network provider, they agree to accept the contracted fee as payment in full for fees and services. However, when you use an out-of-network provider, your coinsurance will be higher and you may be responsible for any costs that exceed the contracted fee established by the BCBSAZ network.

***Please note: The out-of-network coinsurance for all plans in 2016–2017 will be 50%, with no out-of-pocket spending limit.***

***To gain the best savings, use in-network providers. The coinsurance is 80% in-network, with a limit on your annual out-of-pocket spending.***



## Prescription Drugs

The medical plan includes the prescription drug coverage listed in the 2016–2017 medical benefits chart. With the HDHP, your deductible must be met before the plan pays for prescription drug benefits. Prescription drug benefits are paid based on a formulary (called “Preferred”), which is a list of drugs that are covered under the plan. The medicines that are covered under the outpatient prescription drug benefits fall into three categories: generic, preferred brand name, and non-preferred brand name. CVS/Caremark is the pharmacy benefit manager for APEHP. Most retail pharmacies are members of the CVS/Caremark network.



### Getting the Most from Your Prescription Benefit

The following tips can help reduce the amount of money you pay for prescriptions:

- **Generic medications** are a less expensive option than brand name drugs. Before you fill a prescription, ask your doctor if you can substitute a generic drug for a brand medication.
- **Pill splitting** can help save money without sacrificing drug effectiveness or safety. Some tablets are available at double the dose and at the same or nearly the same cost as lower doses. By splitting the larger doses, you can essentially get two doses for the price of one. There are limitations, however, on the types of pills you can split. Time-release medications and medications in capsule form, for example, cannot be split. Ask your doctor and pharmacist if your medication is available in larger doses, and if it can be split to help save you money.
- **Buy medications through the mail.** Ask your doctor for a 90-day prescription for any maintenance medication (for treatment of blood pressure, arthritis, or diabetes, for example), and take advantage of the mail order (home delivery) program. You can save money on copays by getting medications through the mail, and enjoy the convenience of having them delivered directly to your home. **NOTE:** You will need a new prescription to start home delivery with CVS/Caremark.
- **Ask your doctor for samples.** Doctors get free samples from pharmaceutical sales representatives. Don't be afraid to ask if samples are available when you start taking a new medication. Samples allow you to try the new medication to see if it works before you fill an ongoing prescription.
- **Shop around for your medications.** As with everything else you buy, medication prices vary depending on where you purchase them. Call around to different pharmacies to check their prices, and don't forget warehouse stores, which can sometimes offer better prices than traditional retail pharmacies.
- Ask your doctor if there is an over-the-counter alternative to your prescription. Remember that over-the-counter medications usually come in lower strengths; therefore, you should ask your doctor about appropriate dosing.

# MEDICAL PLAN HIGHLIGHTS

## Highlights of the Copay Plan and the \$2,500 HDHP with HSA

The chart below highlights some of the benefits of the Copay Plan and the \$2,500 HDHP with HSA. For more detailed information on the plan, review the Summary Plan Document available from Human Resources.

	Copay Plan		\$2,500 HDHP with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible <sup>(1)</sup> See below	<ul style="list-style-type: none"> <li>▪ \$750/person</li> <li>▪ \$1,500/family of 2</li> <li>▪ \$2,250/family of 3+</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$1,500/person</li> <li>▪ \$3,000/family of 2</li> <li>▪ \$4,500/family of 3+</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$2,500/person</li> <li>▪ \$5,000/family of 2+*</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$5,000/person</li> <li>▪ \$10,000/family of 2+*</li> </ul>
Annual Out-of-Pocket Limit <sup>(2)</sup>	\$5,000/person \$10,000/family of 2+	No maximum	\$3,450/person \$6,550/family of 2+	No maximum
Office Visit	\$20 copay primary care physician; \$40 copay specialist	Plan pays 50%	Plan pays 80%	Plan pays 50%
Well Adult Care	Plan pays 100% No deductible	Plan pays 50% No deductible	Plan pays 100% No deductible	Plan pays 50% No deductible
Well Child Care	Plan pays 100% No deductible	Plan pays 50% No deductible	Plan pays 100% No deductible	Plan pays 50% No deductible
Outpatient Lab and X-ray (including MRI, PET & CT scans)	Plan pays 80%	Plan pays 50%	Plan pays 80%	Plan pays 50%
Urgent Care	\$40 copay	Plan pays 50%	Plan pays 80%	Plan pays 50%
Emergency Room	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Inpatient Hospital	Plan pays 80%	Plan pays 50%	Plan pays 80%	Plan pays 50%
Outpatient Hospital	Plan pays 80%	Plan pays 50%	Plan pays 80%	Plan pays 50%
Outpatient Behavioral Health Visits	\$20 copay/visit No deductible	Plan pays 50%	Plan pays 80%	Plan pays 50%
Retail Prescription Drugs (30-day supply) After Deductible**	You pay: <ul style="list-style-type: none"> <li>▪ Generic: \$10</li> <li>▪ Preferred brand: Greater of \$20 or 30% (maximum of \$45)</li> <li>▪ Non-preferred brand: Greater of \$30 or 50% (maximum of \$90)</li> </ul>		You pay: <ul style="list-style-type: none"> <li>▪ Generic: \$10</li> <li>▪ Preferred brand: Greater of \$20 or 30% (maximum of \$45)</li> <li>▪ Non-preferred brand: Greater of \$30 or 50% (maximum of \$90)</li> </ul>	
Mail Order Drugs (90-day supply) After Deductible**	You pay: <ul style="list-style-type: none"> <li>▪ Generic: \$25 copay</li> <li>▪ Preferred brand: \$50 copay</li> <li>▪ Non-preferred brand: \$90 copay</li> </ul>		You pay: <ul style="list-style-type: none"> <li>▪ Generic: \$25 copay</li> <li>▪ Preferred brand: \$50 copay</li> <li>▪ Non-preferred brand: \$90 copay</li> </ul>	

<sup>(1)</sup> The deductible must be met before the HDHP pays benefits. All benefits are subject to the deductible, unless otherwise noted.

<sup>(2)</sup> The deductible does go towards meeting the annual out-of-pocket limit on the HDHP.

\* The family deductible must be met before claims are paid for any member of the family.

\*\* You must meet the annual medical plan deductible before the HDHP pays a prescription drug benefit, with the exception of certain preventive medications and medical services not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP, please contact the Arizona Public Employers Health Pool at (800) 718-8328.

# HEALTH SAVINGS ACCOUNTS (HSAs)

**A health savings account (HSA) is available when you enroll in the \$2,500 HDHP medical plan.** HSAs are designed to allow individuals to use tax-favored contributions to pay for eligible health care expenses. Unlike a flexible spending account, any money in your HSA will automatically roll over to future plan years.

## How the HSA Works

When you elect coverage under the \$2,500 HDHP medical plan, you will be able to establish an HSA. If you are enrolling for the first time, you will need to complete and return an additional enrollment form. The HSA can help you pay for eligible health care expenses for you and your family, along with expenses not covered by the plan, such as your deductible. The HSA is managed by Health Equity and works like a checking account with a debit card. The funds are available to you once they are deposited into your HSA, and you can use your HSA debit card to make qualifying purchases. If there is not enough money in your HSA to cover an eligible expense, you can be reimbursed for the amount once the funds have been deposited.

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

## Paying Expenses from Your HSA

When you enroll in an HDHP, you pay expenses out of your own pocket until you meet the annual deductible. Then the plan starts to pay benefits. **NOTE:** There are exceptions for certain preventive medications and medical services that are not subject to the deductible. You will find a detailed list of medications that are exempt from this rule under the HDHP on the APEHP website at [www.apehp.org](http://www.apehp.org); or see the APEHP 2016 Maintenance Medications included in your enrollment packet.

Once you enroll in an HDHP, you will receive more information on how to make HSA contributions, and on 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.

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. Also, if you use the money in your HSA for non-eligible expenses, that distribution will be taxed, generally with a 20% penalty.



## Eligible Health Care Expenses

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

## HEALTH SAVINGS ACCOUNTS continued

### When You Enroll in the \$2,500 HDHP Medical Plan

You will need to complete an enrollment form in order to establish your HSA and choose the amount you wish to contribute. You must be HSA-eligible in order to establish an HSA. Check with Human Resources or attend an open enrollment meeting for more information.

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

### Tax Considerations

With an HSA, you are responsible for determining whether or not an expense is eligible to be paid from your account. In addition, you cannot claim a tax deduction for any health care expense reimbursed from your HSA. 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.



### 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, and
- cannot be claimed as a dependent on someone else’s tax return.

### Five Reasons to Enroll in an HSA

1. Easy-to-use online access to claims and payments. You can go online anytime to check your account balance, pay bills, or get reimbursements.
2. Live member services specialists available 24/7. Get the help you need when you need it. You can get personalized assistance from a specialist anytime, day or night.
3. Answers that are just a phone call away. You can rely on a live member services specialist when you need help negotiating payment schedules with a provider, finding the average costs for treatments and prescriptions within your zip code area, or simply learning safe, effective ways to save on your health care costs.
4. Safe, tax-free growth for your money. Your cash deposits are FDIC-insured. In addition, you’ll be earning tax-free interest. Even if you don’t use all of the money in your account, your account balance will continue to grow each year, and you won’t have to pay taxes on any interest earned.
5. No “use-it-or-lose-it” restriction. The money in your account can be used in years when you have greater-than-expected health care expenses. Or, at retirement, you can use the money to help pay for retiree health expenses.

For more information, call the HSA administrator, Health Equity, at (866) 346-5800, or visit [www.healthequity.net/apehp](http://www.healthequity.net/apehp).

To be eligible to contribute to an HSA, you may generally only have health coverage through a high deductible health plan (HDHP). Once you are enrolled in an HDHP, federal regulations place a number of restrictions on who is eligible to make contributions to an HSA during the year. Some of the more important regulations are outlined below:

- If you have any type of Medicare coverage, neither you nor your employer may contribute to your HSA. If your spouse has Medicare but you do not, you may contribute to your HSA as individual coverage, but not family coverage.
- You and your employer may not contribute to your HSA if you are covered by another health plan (unless that other health plan is also a qualified HDHP). For example, if you are covered under your spouse’s medical plan, you may only contribute to your HSA if your spouse’s medical plan is ALSO a qualified HDHP.
- Participation in other types of coverage, such as veterans’ benefits, Indian Health Services, onsite clinics, Tricare, Medicaid, mini-med plans, or supplemental medical insurance may also preclude you and your employer from contributing to an HSA. When in doubt, contact the Arizona Public Employers Health Pool at (800) 718-8328.
- You and your spouse may not be enrolled in the HDHP with HSA and also be enrolled in a Health Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) that reimburses for medical services. If you enroll in the HDHP with HSA, you may only enroll in a Dependent Care FSA.

**Examples: Here are two examples illustrating how you can use an HSA to help pay for deductibles and other qualified medical expenses:**

**Example One**

Joe elects individual coverage in the **\$2,500 HDHP**. On July 1, he puts the maximum (set by the IRS) of \$3,350 in his HSA. Here are Joe’s in-network medical expenses for 2016–2017:

Service/benefit	Amount	What’s covered	HSA Balance
<b>Annual HSA contribution</b>			<b>\$3,350</b>
Annual physical	\$300	Plan pays 100% (because it’s well adult care).	\$3,350
Hospital visit	\$750	HSA pays \$750. Plan does not begin to pay 80% coinsurance until deductible has been met.	\$ 2,600
Prescriptions	\$450	HSA pays \$450.	\$ 2,150
X-rays, MRI	\$1,500	HSA pays \$1,300. <b>Joe has now met his \$2,500 deductible.</b> The plan then pays 80% of the \$200 balance, or \$160; the HSA pays the remaining 20% of the balance, or \$40.	\$810

*At year-end, Joe received \$3,000 in services/benefits; his HSA paid for \$2,540, and the plan paid for \$460. Joe has \$810 remaining in his HSA that rolls over in 2017–2018 plan year.*

**Example Two**

Fred and Sally elect family coverage (for themselves and their two children) in the \$2,500 HDHP. The family deductible is \$5,000. On July 1, they put the maximum (set by the IRS) of \$6,750 in their HSA. Here are the family medical expenses for 2016–2017:

Service/benefit	Amount	What’s covered	HSA Balance
<b>Annual HSA contribution</b>			<b>\$ 6,750</b>
Annual physical	\$1,000	Plan pays 100% (because it’s well adult and well child care).	\$ 6,750
Hospital visit	\$4,000	HSA pays \$4,000. Plan does not begin to pay 80% coinsurance until deductible has been met.	\$ 2,750
Prescriptions	\$400	HSA pays \$400.	\$ 2,350
Office visits (colds, flu)	\$500	HSA pays \$500. Plan does not begin to pay 80% coinsurance until deductible has been met.	\$ 1,850

*At year-end, Fred and Sally received \$5,900 in services/benefits; their HSA paid for all of it (with the exception of the physical examinations, which are covered by the plan at 100%). Because they did not meet their \$5,000 family deductible, the plan’s coinsurance did not apply. Fred and Sally have \$1,850 remaining in their HSA that will roll over in 2017–2018 plan year.*

## WELLNESS BENEFITS



**We want to help you stay healthy.**

**Make this the year  
you really focus on your  
health and well-being!**

**Note: Your physician must  
use wellness codes when billing  
these services to the plan, or they will  
not be recognized as wellness and  
will not be covered at 100%.**

**The following medical plan benefits are covered 100% per plan year, with no deductible, when obtained from in-network providers:**

- Female adult physical exams and annual well woman exams
- Contraceptives (generic) for women
- Screening mammogram (once per year beginning at age 35)
- Prostate screenings like Prostate Specific Antigen (PSA) blood test
- Adult physical exam, expanded to cover blood pressure, weight, personal and family history, general physical exam, breast exam, testicular exam, and skin cancer exam
- Annual screening pap smear and lab work
- Cholesterol or lipid panel screening
- Screening for sexually transmitted diseases (STDs), including chlamydia, syphilis, and gonorrhea infections (annually for sexually active women ages 25 and younger, and other women at-risk)
- FOBT: Fecal Occult Blood Test, a take-home lab test (e.g., Guaiac lab test or newer Fecal Immunochemical Test (FIT) such as InSure to take home, collect specimen, and return to lab)
- Screening abdominal ultrasound (once for men ages 65 to 75 who have ever smoked)
- CDC-recommended adult immunizations for MMR, meningitis, polio, hepatitis A and B, and chickenpox (varicella)
- Blood glucose screening lab work
- Up to three visits with a dietician
- Hearing exam (also called an audiometry exam)
- HPV immunization
- Female sterilization
- Annual flu shot (influenza vaccine)
- Screening colonoscopy (Covered 100 percent in-network with no deductible. Not covered out-of-network. Payable once every 10 years starting at age 50. May be payable at a younger age, or more frequently with proof of first-degree relative with a history of colorectal cancer or familial adenomatous polyposis or hereditary familial adenomatous polyposis or hereditary non-polyposis colorectal cancer.)
- Well child exam visits and CDC-recommended immunizations
- Well child physical exam for sports
- Prenatal vitamins and certain over-the-counter drugs prescribed by a provider, payable under the prescription plan (see retail/mail order prescription drug benefit)

## EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life isn't always easy—but you don't have to face it alone. APEHP continues to offer an employee assistance program (EAP) to help you through life's rough spots. Under the EAP, both you and your family can receive a variety of counseling services to help identify and address problems that impact your life—all at no additional cost to you.

EAP Preferred offers our employees and their family members professional, confidential assistance. You can receive up to six counseling sessions per issue with EAP counselors who are state licensed or certified master's- or doctoral-level clinicians with years of counseling experience. In addition, many are certified employee assistance professionals with a unique understanding of the interaction between personal and workplace issues. These counselors can assist with individual, family, and employment problems, such as work-related stress, substance abuse, relationship or marital conflict, parent-child conflict, depression, anxiety, unresolved grief, and domestic violence. Counselors can also help with referrals to doctors and to sources of legal or financial assistance.

For more information, log on to the EAP website at [www.eappreferred.com](http://www.eappreferred.com) and click on the link to My Life Values.

Your user name is **APEHP**; your password is **eappreferred**.

For an appointment or additional information, call: **(800) 327-3517, ext. 2**

- **Free confidential counseling**
- **Counseling near work or home**
- **Counselor availability, 24 x 7**
- **Legal, financial, elder/child care, and other services/assistance**



# DENTAL PLAN BENEFITS

## Highlights of the Delta Dental Plan of Arizona

Routine Services	Basic Services	Major Services	Orthodontic Services
Deductible: None	Deductible: \$50 per person/\$150 per family		Deductible: None
Covered at 100%	Covered at 80%	Covered at 50%	Covered at 50%
<p><b>Diagnostic</b> Exams, evaluations or consultations (2 times a year) X-Rays:</p> <ul style="list-style-type: none"> <li>• Full Mouth/Panorex or vertical bitewings (1 time in a 3 year period)</li> <li>• Bitewing (2 times a year)</li> <li>• Periapical</li> </ul> <p><b>Preventative</b></p> <ul style="list-style-type: none"> <li>• Routine cleanings (2 times a year)</li> <li>• Topical applications of fluoride (children up to age 17 only, 2 times a year)</li> <li>• Space maintainers (for missing posterior primary (baby) teeth, up to age 14)</li> </ul>	<p><b>Fillings</b></p> <ul style="list-style-type: none"> <li>• Silver amalgam and for front teeth only, synthetic tooth color fillings (1 time per surface every 2 years)</li> </ul> <p><b>Oral Surgery</b></p> <ul style="list-style-type: none"> <li>• Extractions</li> </ul> <p><b>Endodontics</b></p> <ul style="list-style-type: none"> <li>• Root Canal Treatment (permanent teeth)</li> <li>• Pulpotomy (baby teeth)</li> </ul> <p><b>Periodontics</b></p> <ul style="list-style-type: none"> <li>• Treatment of gum disease (non-surgical: 1 time every 2 years; surgical: every 3 years)</li> </ul> <p><b>Emergency</b></p> <ul style="list-style-type: none"> <li>• Treatment for the relief of pain</li> </ul>	<p><b>Prosthodontics</b></p> <ul style="list-style-type: none"> <li>• Bridges</li> <li>• Partial dentures</li> <li>• Complete dentures</li> </ul> <p><b>Restorative</b></p> <ul style="list-style-type: none"> <li>• Crowns</li> <li>• Onlays</li> </ul> <p><b>Bridges &amp; Denture Repair</b></p> <ul style="list-style-type: none"> <li>• Repair of such appliances to their original condition including relining of dentures</li> </ul> <p><b>Replacements</b></p> <ul style="list-style-type: none"> <li>• A five year waiting period applies to all major services including lost, misplaced or stolen bridges or dentures and replacement restorations.</li> </ul>	<ul style="list-style-type: none"> <li>• Benefit for children, age 8 or older</li> <li>• Children must be banded prior to age 17</li> <li>• Lifetime Orthodontia benefit limited to a maximum of \$1,000 per patient (payable in 2 payments upon initial banding and 12 months after).</li> <li>• This maximum is separate from the calendar year maximum for your other dental benefits.</li> </ul>
<p><b>Annual Dental Plan Maximum: \$1,500 per person on routine, basic and major services.</b></p>			



For a list of participating providers in the Delta Dental Premier Network, visit:  
[www.deltadentalaz.com](http://www.deltadentalaz.com)

# VISION PLAN OPTIONS



*You have the opportunity to purchase one of the two VSP Plans outlined below.*

## Voluntary VSP Plan 1

When you see a VSP provider:

- Wellness Vision Exam — every 12 months after a \$10 copay

### *Prescription Glasses*

*Lenses — every 12 months after a \$10 copay*

- Single vision, lined bifocals and lined trifocals
- Polycarbonate lenses for dependent children

*Frames — every 24 months after a \$10 copay*

- \$130 allowance for frames of your choice
- 20% off amount over your allowance

**or**

*Contact Lenses — every 12 months after a \$10 copay*

## Voluntary VSP Plan 2

When you see a VSP provider:

- Wellness Vision Exam — every 12 months after a \$10 copay

### *Prescription Glasses*

*Lenses — every 12 months after a \$25 copay*

- Single vision, lined bifocals and lined trifocals
- Polycarbonate lenses for dependent children

*Frames — every 24 months after a \$25 copay*

- \$130 allowance for frames of your choice
- 20% off amount over your allowance

**or**

*Contact Lenses — every 12 months after a \$25 copay*

## LIFE, AD&D AND STD COVERAGE

### Life & Accidental Death and Dismemberment (AD&D) Insurance

With your Town-paid basic life insurance, you get coverage of 1½ times your basic annual earnings, with a minimum of \$50,000 and a maximum of \$150,000. You do not need to enroll; you are automatically covered for life insurance. You may also elect voluntary dependent life coverage (\$10,000 for spouse and \$5,000 per child) for \$3.69 per month.

#### Accelerated Death Benefit (living benefit):

Those who are terminally ill and insured with less than 12 months' life expectancy may apply to have up to 75% of their life insurance early.

**AD&D coverage includes 24-hour coverage and a seat belt benefit.**

### Short-Term Disability (STD) Insurance

The Town pays 100% of the premium for all eligible employees. Should you become partially or totally disabled due to a sickness or non-work related injury, Standard Insurance will pay a weekly benefit of 66⅔% of the first \$1,500 of your pre-disability earnings, reduced by deductible income.

- Maximum weekly benefit is \$1,000; Minimum weekly benefit is \$15
- Waiting benefit period—90 days for disability caused by accident or injury
- Maximum benefit period—90 days, minus the length of the benefit waiting period.

## AFLAC Supplemental Voluntary Plan Benefits

- Benefits paid directly to insured, unless assigned
- Pays regardless of other insurance
- Payroll rates may be continued when employment terminates or at retirement
- Guaranteed and renewable for life

#### Accident Insurance

- Payments for emergency doctor visits, follow-up or referral visits, hospitalization, specific injuries/treatments/surgeries, ambulance, appliances, physical therapy, annual wellness procedures and more.

#### Cancer Expense Protection

- Covers ALL types of cancer
- Internal cancer survivors can obtain coverage after 5 years of remission
- Benefits paid for annual wellness diagnostic tests, initial diagnosis of malignancy, hospitalization, radiation/chemotherapy, in- or outpatient surgery/anesthesia, blood/plasma, prosthesis, ambulance, travel/lodging, bone marrow transplantation, stem cell transplantation, home health care, National Cancer Institute (NCI) evaluation/consultation and more.

#### Personal STD (Coverage 1-90 days)

- Provides both accident and sickness disability
- Maternity leave covered after the first 10 months
- Complications of pregnancy covered as sickness

#### Specified Health Event/Intensive Care

- Covers any Intensive Care Confinement
- Progressive Benefit for ICU/Step down ICU confinement
- Hospital confinement benefit
- Continuing care benefit
- Organ transplant benefit
- Air and Ground ambulance benefit

#### Voluntary Life Insurance

- Amounts up to \$200,000
- Includes waiver of premium
- Includes accelerated death benefit
- Spouse or children coverage available

**To learn more about AFLAC, please attend one of the scheduled meetings. You must meet with an AFLAC representative if you would like to make changes or add coverage.**

# IMPORTANT PLAN INFORMATION

## Mid-Year Changes To Your Health Care Benefit Elections

**IMPORTANT:** After this open enrollment period is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents until next year's open enrollment, unless you have a special enrollment event or a mid-year change-in-status event as outlined below:

**Special Enrollment Event:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

To request special enrollment or obtain more information, contact the Arizona Public Employers Health Pool at (800) 718-8328.

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

- Change in legal marital status (e.g., marriage, divorce/legal separation, death).
- Change in number or status of dependents (e.g., birth, adoption, death).
- Change in employee's/spouse's/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).

**You must notify the plan in writing within 31 days of the mid-year change-in-status event by contacting the Arizona Public Employers Health Pool at (800) 718-8328. The plan will determine if your change request is permitted and if so, changes will become effective prospectively on the first day of the month following the approved change-in-status event (except for the case of newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).**



- 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's or spouse's plan.
- Changes consistent with special enrollment rights and FMLA leaves.

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

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

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

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the Arizona Public Employers Health Pool at (800) 718-8328.

## COBRA Coverage Reminder

In compliance with a provision of 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 coverage when qualifying events occur, and, as a result of the qualifying event, coverage for that qualified beneficiary ends. Qualified beneficiaries who elect COBRA continuation coverage must pay for it at their own expense.

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

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

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

In order to have the opportunity to elect COBRA coverage following 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 the event occurs.** The notice should be sent to the Arizona Public Employees Health Pool via first class mail, and should 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 the Arizona Public Employers Health Pool at (800) 718-8328 and ask to speak with a representative.

## Direct Access to Primary Care Provider (PCP) and OB/GYN Provider:

The medical plans offered by APEHP 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 a non-network provider.

You also do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Arizona Public Employers Health Pool at (800) 718-8328 and ask to speak with a representative.

## Women's Health and Cancer Rights Act of 1998 (WHCRA) Reminder

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact the Arizona Public Employers Health Pool at (800) 718-8328 and ask to speak with a representative.

## 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 the Arizona Public Employers Health Pool representative.

## 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 he/she meets the eligibility requirements to open an HSA and to have contributions made to that HSA**, 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 are not 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 consider whether enrolling in the medical plan that is paired with a health savings account is a wise choice.
- You may not be claimed as a dependent on someone else's tax return.
- Individuals can't open an HSA, or have contributions made to the HSA during the year, if a spouse's health insurance, Health Care Flexible Spending Account (FSA) or health reimbursement arrangement (HRA) can pay for any of the individual's medical expenses before the HSA-qualified plan deductible is met. This means that a standard general purpose Health Care Flexible Spending Account (FSA) may make you ineligible to open an HSA and have contributions made to the HSA during the year.

## 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, you need to be sure that you understand whether the prescription drug coverage that you elect under this Plan is or is not creditable (as valuable as) Medicare's prescription drug coverage.

APEHP has determined that the prescription drug coverage under the Copay and the \$2,500 HDHP are "creditable".

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

If you have questions about what this means for you, review the plan's Medicare Part D Notice of Creditable Coverage.

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

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

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

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

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

***If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility –***

<p><b>ALABAMA – Medicaid</b> Website: <a href="http://www.myalhipp.com">www.myalhipp.com</a> Phone: 1-855-692-5447</p>	<p><b>KENTUCKY – Medicaid</b> Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570</p>
<p><b>ALASKA – Medicaid</b> Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529</p>	<p><b>LOUISIANA – Medicaid</b> Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a> Phone: 1-888-695-2447</p>
<p><b>COLORADO – Medicaid</b> Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a> Medicaid Customer Contact Center: 1-800-221-3943</p>	<p><b>MAINE – Medicaid</b> Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a> Phone: 1-800-442-6003 TTY: Maine relay 711</p>
<p><b>FLORIDA – Medicaid</b> Website: <a href="http://flmedicaidprecovery.com/">http://flmedicaidprecovery.com/</a> Phone: 1-877-357-3268</p>	<p><b>MASSACHUSETTS – Medicaid and CHIP</b> Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Phone: 1-800-462-1120</p>
<p><b>GEORGIA – Medicaid</b> Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-450</p>	<p><b>MINNESOTA – Medicaid</b> Website: <a href="http://mn.gov/dhs/ma/">http://mn.gov/dhs/ma/</a> Phone: 1-800-657-3739</p>
<p><b>INDIANA – Medicaid</b> Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0964</p>	<p><b>MISSOURI – Medicaid</b> Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005</p>
<p><b>IOWA – Medicaid</b> Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562</p>	<p><b>MONTANA – Medicaid</b> Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084</p>
<p><b>KANSAS – Medicaid</b> Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> Phone: 1-785-296-3512</p>	<p><b>NEBRASKA – Medicaid</b> Website: <a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a> Phone: 1-855-632-7633</p>

<p><b>NEVADA – Medicaid</b>  Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a>  Medicaid Phone: 1-800-992-0900</p>
<p><b>NEW HAMPSHIRE – Medicaid</b>  Website: <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</a>  Phone: 603-271-5218</p>
<p><b>NEW JERSEY – Medicaid and CHIP</b>  Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Medicaid Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710</p>
<p><b>NEW YORK – Medicaid</b>  Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>
<p><b>NORTH CAROLINA – Medicaid</b>  Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a>  Phone: 919-855-4100</p>
<p><b>NORTH DAKOTA – Medicaid</b>  Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a>  Phone: 1-844-854-4825</p>
<p><b>OKLAHOMA – Medicaid and CHIP</b>  Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>
<p><b>OREGON – Medicaid</b>  Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a>  <a href="http://www.hijossaludablesoregon.gov">http://www.hijossaludablesoregon.gov</a>  Phone: 1-800-699-9075</p>
<p><b>PENNSYLVANIA – Medicaid</b>  Website: <a href="http://www.dhs.pa.us/hipp">http://www.dhs.pa.us/hipp</a>  Phone: 1-800-692-7462</p>
<p><b>RHODE ISLAND – Medicaid</b>  Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>  Phone: 401-462-5300</p>
<p><b>SOUTH CAROLINA – Medicaid</b>  Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>

<p><b>SOUTH DAKOTA - Medicaid</b>  Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>  Phone: 1-888-828-0059</p>
<p><b>TEXAS – Medicaid</b>  Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a>  Phone: 1-800-440-0493</p>
<p><b>UTAH – Medicaid and CHIP</b>  Website:  Medicaid: <a href="http://health.utah.gov/medicaid">http://health.utah.gov/medicaid</a>  CHIP: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a>  Phone: 1-877-543-7669</p>
<p><b>VERMONT– Medicaid</b>  Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>  Phone: 1-800-250-8427</p>
<p><b>VIRGINIA – Medicaid and CHIP</b>  Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a>  Medicaid Phone: 1-800-432-5924  CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a>  CHIP Phone: 1-855-242-8282</p>
<p><b>WASHINGTON – Medicaid</b>  Website: <a href="http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx">http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx</a>  Phone: 1-800-562-3022 ext. 15473</p>
<p><b>WEST VIRGINIA – Medicaid</b>  Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a>  Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p><b>WISCONSIN – Medicaid and CHIP</b>  Website:  <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a>  Phone: 1-800-362-3002</p>
<p><b>WYOMING – Medicaid</b>  Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a>  Phone: 307-777-7531</p>

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
**[www.dol.gov/ebsa](http://www.dol.gov/ebsa)**  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
**[www.cms.hhs.gov](http://www.cms.hhs.gov)**  
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

### **Important Notice from the Arizona Public Employers Health Pool (APEHP) about Prescription Drug Coverage for People with Medicare.**

**This notice is for people with Medicare.**

**Please read this notice carefully and keep it where you can find it.**

This Notice has information about your current prescription drug coverage with the Arizona Public Employers Health Pool (APEHP) and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

**APEHP has determined that the prescription drug coverage under the Copay and the \$2,500 HDHP prescription drug plan options are "creditable".**

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan option noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under any of the APEHP medical plan options and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

### REMEMBER TO KEEP THIS NOTICE

**If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

### **WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?**

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15<sup>th</sup> through December 7<sup>th</sup>); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

### **YOUR RIGHT TO RECEIVE A NOTICE**

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

### **WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)**

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next Medicare open enrollment period in order to enroll for Medicare prescription drug coverage.

## WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
<b>Option 1</b>	You can select or keep your current medical and prescription drug coverage <b>under any of the APEHP medical plan options and you do not have to enroll in a Medicare prescription drug plan.</b>	<ul style="list-style-type: none"> <li>• You will continue to be able to use your prescription drug benefits through any of the APEHP medical plan options.</li> <li>• You may, in the future, enroll in a Medicare prescription drug plan during Medicare’s annual enrollment period (during October 15th through December 7th of each year).</li> <li>• As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.</li> </ul>
<b>Option 2</b>	<p>You can select or keep your current medical and prescription drug coverage under any of the APEHP medical plan options and also enroll in a Medicare prescription drug plan.</p> <p>If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.</p>	<p>Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.</p> <p>Having dual prescription drug coverage under this Plan and Medicare means that you will still be able to receive all your current health coverage and this Plan will coordinate its drug payments with Medicare, as follows:</p> <ul style="list-style-type: none"> <li>• for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary.</li> <li>• for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary.</li> <li>• Note that you may not drop just the prescription drug coverage under any of the APEHP medical plan options. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan’s next Open Enrollment period.</li> <li>• Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:               <ul style="list-style-type: none"> <li>• PDPs may have different premium amounts;</li> <li>• PDPs cover different brand name drugs at different costs to you;</li> <li>• PDPs may have different prescription drug deductibles and different drug copayments;</li> <li>• PDPs may have different networks for retail pharmacies and mail order services.</li> </ul> </li> </ul> <p>***<b>IMPORTANT NOTE:</b> If you are enrolled in the High Deductible Health Plan (HDHP) with the Health Savings Account (HSA) you may not continue to make contributions to your HSA once you are enrolled in Medicare including being enrolled in a Medicare Part D drug plan.</p>

## FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite [www.medicare.gov](http://www.medicare.gov) por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en [www.socialsecurity.gov](http://www.socialsecurity.gov) por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

**For people with limited income and resources**, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

### For more information about this notice or your current prescription drug coverage contact:

**APEHP Pool Advocate**  
333 East Osborn Road, Suite 300  
Phoenix, AZ 85012  
(800) 718-8328

As in all cases, the Arizona Public Employers Health Pool (APEHP) and the Town of Paradise Valley reserve the right to modify benefits at any time, in accordance with applicable law. This document (dated April 23, 2016) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

# IMPORTANT CONTACTS

<p><b>Plan Administration and Employee Advocate</b></p>	<p><b>Arizona Public Employers Health Pool (APEHP)</b>          Member Services: (800) 718-8328  <a href="http://www.apehp.org/">www.apehp.org/</a></p>
<ul style="list-style-type: none"> <li>• <b>Eligibility and Benefits Information</b></li> <li>• <b>Benefits Information</b></li> <li>• <b>Medical Plan Claims Administrator and Appeals</b></li> <li>• <b>Flexible Spending Account (FSA)</b></li> <li>• <b>COBRA Administration</b></li> </ul>	<p><b>AmeriBen Medical Management</b>          P.O. Box 7186, Boise, ID 83707          Member Services: (866) 955-1485  <a href="http://www.myameriben.com">www.myameriben.com</a></p>
<p><b>HSA Administration</b></p>	<p><b>Health Equity</b>          15 W. Scenic Pointe Drive, Suite 400, Draper, UT 84020          Member Services: (866) 346-5800  <a href="http://www.healthequity.net/apehp">www.healthequity.net/apehp</a></p>
<p><b>Medical Plan Provider Network</b></p>	<p><b>BlueCross BlueShield of Arizona</b>  <a href="http://www.azblue.com">www.azblue.com</a></p> <p><i>BlueCross BlueShield® of Arizona (BCBSAZ), an independent-licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield outside of Arizona.</i></p>
<p><b>Mayo Clinic Arizona</b></p>	<p><b>Mayo Clinic Arizona</b>          Appointment Office: (480) 301-1735  <a href="http://mayoclinic.org/arizona/">mayoclinic.org/arizona/</a></p>
<p><b>Dental Plan</b></p>	<p><b>Delta Dental</b>          P.O. Box 43026, Phoenix, AZ 85080-3026          Member Services: (800) 352-6132  <a href="http://www.deltadentalaz.com">www.deltadentalaz.com</a></p>
<p><b>Vision Plan</b></p>	<p><b>Vision Service Plan (VSP)</b>          Member Services: (800) 877-7195  <a href="http://www.vsp.com">www.vsp.com</a></p>
<p><b>Prescription Drugs (Retail and Mail Order)</b></p>	<p><b>CVS/Caremark</b>          Customer Care: (800) 552-8159  <a href="http://www.caremark.com">www.caremark.com</a></p>
<p><b>Employee Assistance Program (EAP)</b></p>	<p><b>EAP Preferred</b>          Member Services: (800) 327-3517, ext. 2  <a href="http://www.eappreferred.com">www.eappreferred.com</a>          User name: APEHP; Password: eappreferred</p>

*This Enrollment Guide is intended to be only an overview of the benefits program. Complete details about how the plans work are included in the policies, summary plan descriptions, and plan documents (legal documents), which are available online or from your HR Manager on request. If there are any inconsistencies between this Enrollment Guide and the legal documents, the legal documents will govern. The Town of Paradise Valley reserves the right to change or end the benefits program at any time.*