APACHE COUNTY
ENROLLMENT GUIDE 2020-2021

ARIZONA LOCAL GOVERNMENT
EMPLOYEE BENEFIT TRUST
Dear Employee:

This booklet contains important information regarding your benefits for the **2020-2021** plan year.

**Enrollment:** All eligible employees wishing to make benefit election changes should do so during the open enrollment period from May 1 to May 22. Enrollment will continue to be through the SmartBen online portal at [www.smartben.com](http://www.smartben.com).

Open enrollment for the County’s 2020-2021 plan year will begin at **12:01 AM on Friday, May 1, 2020** and will **end on Friday, May 22, 2020 at 11:59 PM – Arizona time**.

Please review the enclosed materials for detailed explanations of the plans available to you and your family.

**PPO:** The Preferred Provider Organization will continue to be Blue Cross Blue Shield of Arizona. A list of providers can be found at [www.azblue.com/chsnetwork](http://www.azblue.com/chsnetwork) or by calling AmeriBen at 877-635-2912.

**Teladoc:** Teladoc provides access to a national network of U.S. board-certified doctors including pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat, and prescribe medication (when necessary) for many medical issues via phone or online video consultations. Teladoc does not replace the existing primary care physician relationship, but is available as a convenient, affordable alternative to high-cost Emergency Rooms and Urgent Care Centers.

Doctors can diagnose and treat many non-emergency conditions, including:

1. Cold and flu symptoms
2. Respiratory infection
3. Sinus problems
4. Ear infections
5. Skin problems
6. And more!

Get started today by calling 1-800-TELADOC (835-2362) or online at [www.teladoc.com](http://www.teladoc.com).

**Prescription Drugs:** The Prescription Benefit Manager will continue to be Navitus. As in the past, a list of providers can be found at [www.navitus.com](http://www.navitus.com).

**Medical Review (Pre-certification, Second Opinions):** The plan will continue to use American Health Group (AHG) for pre-certification. AHG must be notified for all non-emergency hospital admissions at least 72 hours in advance or within 48 hours after emergency admissions. Please refer to your summary plan description for additional services that require pre-certification. Failure to pre-certify may result in a reduction or denial of benefits. Please see page 12 for entire list.
Employee Assistance Program (EAP) and Inpatient or Outpatient Mental Health and Substance Abuse Treatment: Holman Group of Arizona provides 3 free visits for a broad range of mental health and related areas of frequent concern to employees and their covered dependents through a network of Arizona and nationwide providers.

**Benefit for First Responders and Public Safety Personnel (HB 2502)**

The EAP benefit extends beyond the 3-session model for First Responders and Public Safety Personnel including fire fighters, police and sheriff officers, security personnel, and personnel working in those departments who experience a traumatic event in their line of work. The number of EAP sessions extends to a total of 12 sessions. For First Responders only, the benefit can extend to a total of 36 sessions if needed upon the recommendation of a licensed mental health professional, and the counseling visits occur within one year of the first visit.

Additionally, if you or a covered family member are seeking inpatient or outpatient treatment (beyond what is offered through the EAP), Holman Group of Arizona provides pre-certification and case management serves for these treatment regimens. For information or to schedule a confidential EAP session, or for mental health and/or substance abuse treatment (inpatient or outpatient), call Holman Group of Arizona at 800-321-2843.

**Vision Coverage**: Vision benefits will continue to be offered through VSP.

**Dental Coverage**: Dental coverage will continue to be offered through Ameritas. A list of in-network dentists can be found at [www.ameritasgroup.com](http://www.ameritasgroup.com).

**Voluntary Life**: **Effective July 1, 2020**, Voluntary Life will transition from Mutual of Omaha to [Securian](https://www.securian.com). Current Employees and Dependents will be offered a **ONE TIME** Open Enrollment opportunity. Please see page 24 of this guide which outlines the new guidelines for current Employees and New Hires.

**Basic Life**: All eligible employees are automatically enrolled in Basic Life.

**Short Term Disability**: All eligible employees are automatically enrolled in Short Term Disability.
AZLGBET – 2020-2021 Plan Year Changes

The following changes will become effective July 01, 2020. A brief overview is being provided below and may be outlined in greater detail throughout the guide where applicable.

PRESCRIPTION DRUG – Both Plans – Implement Copay Max Program

- Applies only to Specialty Medications obtained through the Navitus Specialty Pharmacy Lumicera
- If you are an EPO Plan Participant instead of paying your $100 copay, your copay will be $0
- If you are a HDHP Participant instead of paying the full cost of your prescription until you have met your deductible/Max Out-of-Pocket Maximum, your cost-sharing will be $0.

*IF YOUR MEDICATION QUALIFIES, YOU WILL BE AUTOMATICALLY ENROLLED*

DENTAL – Both Plans

- Increase Annual Maximum from $1,750 to $2,000
- Increase Orthodontic Lifetime Maximum from $1,750 to $2,000

BASIC LIFE

Remove Age Reduction

- Coverage for employees and spouses will no longer have age reductions
- Previously reduced coverage for employees age 70+ will be restored to the full benefit amount

Add Line of Duty Coverage

- A Line of Duty benefit has been added for all Public Safety Officers. If an accidental death occurs while performing their customary duties for the employer, the principal AD&D sum will be increased by 100%, not to exceed $100,000.
- Included in benefit are; Police Officers, Firefighters, Paramedics, Corrections Officers, Probation Officers, Public Transit Officers, Parole Officers, Judicial Officers, and Officially Recognized or Designated Firefighters
**VOLUNTARY TERM LIFE**

- Transition from Mutual of Omaha to Securian
  - One-time Voluntary Term Life opportunity during Open Enrollment
    - Employee - Elect or increase coverage up to a maximum of $300,000
    - Spouse - Elect $10,000 or increase coverage by $10,000 up to a maximum $50,000 (Limited to 100% of Employee’s amount)
    - Child(ren) - Elect $20,000 or increase coverage from $2,000, $5,000, or $10,000 to $20,000 (Limited to 100% of Employee’s amount)
  - One time only Guaranteed Issue
    - Employee - Increased from $200,000 to $300,000
    - Spouse - $50,000 (Limited to 100% of Employee’s amount)
    - Child(ren) - Increased from $2,000, $5,000, or $10,000 to a flat $20,000 (Limited to 100% of Employee’s amount)
  - In the event of a Qualifying Event if coverage was not elected prior
    - Employee - $300,000
    - Spouse - $50,000 (Limited to 100% of Employee’s amount)
    - Child(ren) - $20,000 (Limited to 100% of Employee’s amount)

**WELLNESS**

- Transition from Sweet Savings Diabetes through MyPharmacist Connection to Livongo for Diabetes
  - Implement Livongo for Pre-Disease Management
  - Implement Livongo for Hypertension Management
- Transition from Fitbit to MoveSpring for activity challenges
OPEN ENROLLMENT DATES FOR THE 2020-2021 PLAN YEAR

Open enrollment for the County’s 2020-2021 plan year will begin at 12:01 AM on Friday, May 1, 2020 and will end on Friday, May 22, 2020 at 11:59 PM – Arizona time.

BENEFIT ENROLLMENT
Enrollment online through www.smartben.com is required for the following actions:

- Add or drop coverage and change contribution amounts in the FSA
- Add or drop coverage and change contribution amounts in the HSA
- Add, drop, or change coverage in the Medical, Dental, or Vision plans
- Add or drop dependents in the Medical, Dental, or Vision plans
- Elect coverage for the Voluntary Term Life for Employees and Dependents – One Time Guaranteed Issue Opportunity

See the Online Enrollment Section on page 26 for details about logging in and enrolling via www.smartben.com.
BENEFIT OVERVIEW

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IMPORTANT DATES & INFORMATION

OPEN ENROLLMENT DATES:  Begins at 12:01 AM Friday, May 1, 2020 – Friday, May 22, 2020 at 9:00 PM – Arizona Time

ENROLLMENT GUIDE:
This booklet is an overview for all your benefit decisions. We believe you will find it very helpful in understanding your benefit options. Should you have questions or need additional assistance with understanding the benefits offered to you during open enrollment, please refer to the Vendor Reference information on page 9.

ONSITE HEALTH PLAN EDUCATIONAL MEETINGS:
Your Human Resources Department may be hosting onsite educational meetings during May’s open enrollment period; we encourage you to invite your spouse if he/she can attend. Contact your Human Resources Department for the dates of these meetings (if applicable).

DEPENDENT ELIGIBILITY & VERIFICATION:
Employees who wish to add dependents to the health, dental, or vision plans for the 2020-2021 plan year will be required to provide documentation that the person being enrolled is an eligible dependent as defined by the plan. Examples include marriage certificate, birth certificates, tax returns, court orders regarding custody or guardianship, or any other documents that verify dependent status. Failure to submit this information during your initial enrollment or open enrollment, as applicable, will result in your dependents being dropped from the benefit plans.

MEMBER ID CARDS:
Medical/Prescription Cards – Members should retain their current AmeriBen medical/prescription ID card. Alternatively, Members have access to an electronic ID card through AmeriBen’s website at www.MyAmeriBen.com. If you need an additional medical/prescription card, register or log in www.MyAmeriBen.com to submit a request or call AmeriBen Customer Care Center at 1-877-635-2912.

Dental and/or Vision Cards – Members should retain their current dental and/or vision cards. Only those who elect new coverage will receive a new dental and/or vision card.
Claims Administrator for Medical plans
AmeriBen
The friendly and knowledgeable staff at AmeriBen can answer questions about eligibility, health benefits, network providers, and Short-Term Disability.
877-635-2912

Medical Review
American Health Group (AHG)
Medical plan pre-certification, case management and second opinions.
602-265-3800
800-847-7605

Preferred Provider Organization:
Blue Cross Blue Shield of AZ
800-232-2345
www.azblue.com/chsnetwork

Pharmacy Benefits Manager
Navitus Health Solutions, LLC
866-333-2757
www.navitus.com

Telemedicine
Teladoc
Get started today!
800-TELADOC (835-2362)
www.teladoc.com

HSA and FSA Accounts
HealthEquity
866-346-5800
www.healthequity.com

Employee Assistance Program
Holman Group of Arizona
800-321-2843

Behavioral Health
Holman Group of Arizona
Services for mental health and/or substance use disorders
800-321-2843

Vision Coverage
VSP
Eligibility, benefits, claims
800-877-7195
www.vsp.com

Dental Coverage
Ameritas Group
Eligibility, benefits, claims and ID cards.
800-487-5553
www.ameritasgroup.com

Life Insurance
Securian
Death claim forms, claims processing, living benefit, disability waiver, status of claims forms/payment, and continuation of benefits after leaving employment or dependent loss of eligibility.
www.ochsinc.com
800-392-7295

The AZLGBET Website
For information about Arizona Local Government Employee Benefit Trust and your insurance programs, including: Health Benefits, Dental Benefits, Vision Benefits, Life Benefits, Short Term Disability, Wellness Events Calendar, Plan Documents, Member Entities, Vendor Contacts/Links, Legal Notices, Frequently Asked Questions.
www.AZLGBET.com
MEDICAL PLAN INFORMATION

OUR ADMINISTRATOR
AmeriBen is the Third-Party Claims Administrator of our employee group health plan.

Our group health plan is a “self-funded” plan, which means the member counties in the AZLGEBT Trust assume the financial risk for providing healthcare benefits to employees. In practical terms, self-insured employers pay for claims as they are incurred, instead of paying a fixed premium to an insurance carrier, which is known as a fully-insured plan.

Most self-insured employers subcontract this service to a Third-Party Administrator (TPA). TPA’s help employers set up self-insured groups health plans and coordinate provider network agreements.

With over 60 years’ experience and a focus on our unique needs as a plan sponsor, AmeriBen will administer our health plan, as well as provide timely claims payment and outstanding customer service.

THE MEDICAL PLAN OPTIONS
We will continue to offer two different health plan options this year. To be covered in the health plan, you must choose one of the two options described in more detail in this enrollment guide. If you have questions or would like assistance with understanding the plan options, please call AmeriBen at 877-635-2912.

THE AZLGEBT WELLNESS PROGRAM
The federal government mandates 100% coverage of certain preventive care services. A list of these services can be found online at www.healthcare.gov under the prevention and wellness tab.

Additionally, the AZLGEBT medical plans cover specific services over and above those required by the federal government. Please see the plan document for a list of those additional services.

The primary goal of the Wellness Program is a healthier employee population with corresponding management of medical and prescription claims costs. Early Detection, Lifestyle Modification, and Disease Management are just a few of the programs offered through the AZLGEBT Wellness Program. On-site screenings are also available throughout the year for your convenience. Participation is the key to a successful Wellness Program and to a better quality of life.

Take the time to check out the Wellness Program offered to you and your dependents as AZLGEBT participants. It is good for your health!

Additionally, employees who participate in the annual Health Risk Assessments (HRAs) receive a $10 per paycheck reduction in premium.

MENTAL HEALTH AND SUBSTANCE ABUSE
Holman Group of Arizona provides 3 free visits for a broad range of mental health and related areas of frequent concern to employees and their covered dependents through a network of Arizona and nationwide providers. Additionally, if you or a covered family member are seeking inpatient or outpatient treatment (beyond what is offered through the EAP), Holman Group of Arizona provides pre-certification and case management services for these treatment regimens. For information or to schedule a confidential EAP session, or for mental health and/or substance abuse treatment (inpatient or outpatient) call Holman Group of Arizona at 800-321-2843.

Benefit for First Responders and Public Safety Personnel (HB 2502) The EAP benefit extends beyond the 3-session model for First Responders and Public Safety Personnel including fire fighters, police and sheriff officers, security personnel, and personnel working in those departments who experience a traumatic event in their line of work. The number of EAP sessions extends to a total of 12 sessions. For First Responders only, the benefit can extend to a total of 36 sessions if needed upon the recommendation of a licensed mental health professional, and the counseling visits occur within one year of the first visit.
HEALTH BENEFIT TERMS & BILLING:

WHAT IS A COPAYMENT?
A copayment is a fixed amount (for example, $15) you pay for a covered health service, usually when you receive the service. The amount can vary by the type of covered health service.

WHAT IS A DEDUCTIBLE?
A deductible is an amount you could owe during a coverage period (usually one year) for covered healthcare services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also separate deductibles. (For example, if your deductible is $1,000, your plan won’t pay anything until you’ve met your $1,000 deductible for covered health services that are subject to the deductible).

WHAT IS COINSURANCE?
Coinsurance is your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The plan pays the rest of the allowed amount).

HOW DOES MY OUT-OF-POCKET MAXIMUM WORK?
Each plan specifies an out-of-pocket maximum, which is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this maximum, the plan will pay 100% of the allowed amount for covered expenses for the remainder of the coverage period. This maximum helps you plan for health care costs.

The maximum never includes your premium, balance-billed charges, or health care expense your plan doesn’t cover.

Co-payments and deductibles count toward your out-of-pocket maximum.

HOW MUCH IS MY DEDUCTIBLE AND COINSURANCE?
The plan choices you make during the enrollment period determine deductible and coinsurance amounts.

HOW YOU ARE BILLED:

WHAT DOES THE FACILITY BILL FOR?
IS THIS MY ONLY BILL FOR THESE MEDICAL SERVICES, OR CAN I EXPECT TO RECEIVE OTHERS?
When you receive a facility bill for services, it includes many costs: facility charges, equipment, supplies, laboratory/radiology services, and other support services. You may expect to receive bills for medical services from the facility, as well as from the physician and/or other providers who supplied medical services. As a result of government regulations, most facility-based physicians and specialists separately bill their services from the facility. The separate bill will be from your personal physician, surgeon, anesthesiologist, or other independent supplier of medical services.

The chart below gives examples of medical services that require the attention of a physician who will send a separate bill for payment:

<table>
<thead>
<tr>
<th>If you have:</th>
<th>You will also receive a bill from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-rays taken</td>
<td>The radiologist</td>
</tr>
<tr>
<td>Certain lab tests</td>
<td>The pathologist</td>
</tr>
<tr>
<td>Surgery</td>
<td>The anesthesiologist, surgeon, &amp; pathologist</td>
</tr>
<tr>
<td>Visit by your</td>
<td>Your personal physician</td>
</tr>
<tr>
<td>personal physician</td>
<td></td>
</tr>
<tr>
<td>EKG</td>
<td>The cardiologist</td>
</tr>
</tbody>
</table>

ELIGIBILITY AND PRE-CERTIFICATION REQUIREMENTS:

VERIFICATION OF ELIGIBILITY
Contact AmeriBen at 877-635-2912 or log on to www.MyAmeriBen.com. Be sure to verify eligibility and plan benefits before the charge is incurred.
MEDICAL BENEFITS

An emergency room visit for a life- or limb-threatening situation is a covered benefit. Always consider urgent care, Teladoc, or a visit to your Primary Care Physician (PCP) if the condition is not life- or limb-threatening; this could mean significant savings for you and your family. For assistance with urgent care options in your area, contact AmeriBen at 877-635-2912 or look up a BCBSAZ provider at www.azblue.com/chsnetwork.

PRE-CERTIFICATION REQUIREMENTS

The following services, supplies, and care must be pre-certified, or reimbursement from the plan may be reduced. All requests are subject to the plan’s guidelines and medical necessity review.

To pre-certify services, contact American Health Group (AHG): 800-847-7605 or 602-265-3800.

If pre-certification requirements are not met, the provider will be penalized $300. If you have any questions regarding pre-certification, call AHG.

PRE-CERTIFICATION REQUIREMENT LIST

- Inpatient confinements (including rehab & skilled- nursing facilities, & long-term acute care)
- Diagnostic tests with a cumulative total over $1,000
- Outpatient surgical procedures over $1,000
- Injectable medications over $1,000 administered in a physician’s office or in conjunction with Home Health services
- Durable medical equipment over $2,500
- Chemotherapy
- Radiation therapy
- Outpatient rehabilitation services (physical therapy, occupational therapy, speech therapy)
- Organ transplants
- Morbid obesity related procedures, including bariatric surgery
- Psychological and neuropsychological testing
HEALTH SAVINGS ACCOUNTS

TAX-FREE SAVINGS FOR MEDICAL EXPENSES

A HEALTH SAVING ACCOUNT (HSA)

The Health Savings Account (HSA) is administered through HealthEquity

WHAT IS AN HSA?

An HSA account is an individual savings account that can be used to pay for qualified medical expenses. This account is only available if you select the High-Deductible Health Plan (HDHP) option. The HDHP allows you to open an HSA and take advantage of terrific tax savings. The money in your account accumulates on a tax-deferred basis and can be rolled over from year to year. You can save your money for future medical expenses, and as long you use the money for a qualified medical expense, your funds are NEVER taxed.

HOW DOES AN HSA WORK?

A HDHP offers a scientifically lower monthly premium in exchange for a higher deductible. The money you would normally spend on monthly premiums can now be contributed on a pre-tax basis to your HSA account. You will receive a debit card to use for qualified medical expenses, which will draw from your HSA. Distributions from your HSA are tax-free when used to pay for qualified medical expenses. The 2020 maximum contribution limit for single coverage is $3,550, and family is $7,100. HSA participants who are 55 and older can contribute an additional $1,000 for a total of $4,550 for single coverage and $8,100 for family coverage.

HOW CAN I SAVE MONEY WITH AN HDHP & HSA?

• Using HSA dollars to pay for qualified medical expenses is tax-free
• Premiums for HDHPs are lower than traditional plans
• HSAs have a tax-favored status
• Interest earned on the money in an HSA is tax-deferred

WHAT IS CONSIDERED A “QUALIFIED MEDICAL EXPENSE”?

A full list of qualified expenses for an HSA is identified in the Internal Revenue Code Section 213(d).*

Some of the most common expenses include:

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Contact lenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-pocket expenses</td>
<td>Eyeglasses</td>
</tr>
<tr>
<td>LASIK surgery</td>
<td>Office visit co-pays</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Chiropractor visits</td>
</tr>
<tr>
<td>Vaccinations</td>
<td>Dental treatment</td>
</tr>
<tr>
<td>Over-the-counter medications</td>
<td></td>
</tr>
</tbody>
</table>

*You should refer to http://www.irs.gov/pub/irs-pdf/p502.pdf for a full list of qualified expenses. If HSA funds are used for non-qualified medical expenses, those purchases are subject to a 20% penalty tax and will be considered income for tax purposes.
WHAT ARE THE BENEFITS OF HAVING AN HSA ACCOUNT?

A debit card for convenient access to your money and online banking tools.
- The contributions are 100% tax deductible.
- The fund grows tax-deferred.
- The money withdrawn for qualified medical expenses is tax-free.
- The money you put in your HSA can reduce your taxable income.
- You can roll the account balance over from year to year.
- Your HSA is portable and can move with you from job to job.
- After age 65, you can use your HSA account to pay Medicare premiums, deductibles, copays, and coinsurance under any part of Medicare.

HOW DO I PAY THE BILL AT MY DOCTOR’S OFFICE WITH AN HSA?

If you have an HSA, it is important not to overpay for medical expenses. Since you’re paying "cash" from your HSA if you pay the entire bill up front, you may be paying too much since PPO discounts will not have been applied. For example, most claims must be re-priced before you know what you owe. If you pay cash at the time of service, you will likely pay before the network discounts are applied. This may pose a problem if you are reimbursed by your physician’s office, because you have technically made an unqualified withdrawal from your HSA. **We strongly suggest that you wait until you receive your EOB before paying the provider.**
FLEXIBLE SPENDING ACCOUNTS

TAX FREE SAVINGS
The County offers a Flexible Spending Account (FSA) for tax-free savings on eligible medical expenses. The Flexible Spending Account (FSA) is administered through HealthEquity.

Eligible healthcare and dependent care expenses can be paid for on a pre-tax basis when you contribute to an FSA.

FSA ACCOUNTS AVAILABLE
- Full Purpose FSA – Available only to those on the PPO Plan
- Limited Purpose FSA – Available only to those on the HDHP
- Dependent Care FSA

IRS MAXIMUMS FOR AN FSA
Full & Limited Purpose Plans: $2,750/plan year

Dependent Care Plan: $5,000/plan year if married and filing a joint return, or a single parent. If married and filing separately, you may contribute up to $2,500 per year per parent.

The FSA is an annual election; therefore, you must enroll annually to participate. All elected funds must be used by the end of the plan year, June 30th or they will be forfeited. You should plan carefully and contribute only what you estimate your eligible expenses will be.

USING FSA FUNDS
Any member who elects a Full or Limited Purpose FSA will receive a debit card. The elected funds will be loaded on the card and available for use at the start of the plan year. Dependent Care funds are only available as they are contributed. A signed claim form and receipt from a day care with a valid tax ID number must be submitted for reimbursement.

ELIGIBLE EXPENSES
The IRS clearly defines what expenses are eligible. For more information on eligible expenses visit:

CLAIM SUBSTANTIATION
It is important for members to keep all receipts for FSA expenses in the event substantiation is requested. The majority of claims will be auto-substantiated; however, some claims may require a receipt to substantiate them as an eligible expense in order to be deemed reimbursable by the plan.

MANAGING YOUR FSA ACCOUNT(S)
All FSA accounts can be managed through myameriben.com or by downloading the mobile app. By logging on, you can:
- Check your balance
- File claims
## 2020 MEDICAL PLAN OPTIONS

**HIGH-DEDUCTIBLE HEALTH PLAN (HDHP) OUTLINE OF BENEFITS**

<table>
<thead>
<tr>
<th>MEDICAL PLAN FEATURES:</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$3,750</td>
<td>$7,000</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$7,500</td>
<td>$14,000</td>
</tr>
<tr>
<td><strong>Out-of-pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$3,750</td>
<td>$14,000</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$7,500</td>
<td>$28,000</td>
</tr>
<tr>
<td>(Includes deductible)</td>
<td></td>
<td>(Includes deductible)</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>100% no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(services as required by law as well as routine physicals and all AZLGBT onsite screenings)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong> (limited to 26 visits and $40 eligible charge per visit)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>X-ray/Lab (in office)</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>X-ray/Lab (outpatient facility)</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>100% after deductible (waived if admitted)</td>
<td>100% after deductible (waived if admitted)</td>
</tr>
<tr>
<td><strong>Behavioral/Mental Health and Substance Use Disorders – Inpatient</strong> (includes residential treatment)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Behavioral/Mental Health and Substance Use Disorders – Outpatient</strong> (includes partial hospitalization)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong> (The deductible is waived for smoking cessation drugs, prescribed preventive medications, and contraceptives as required by federal law)</td>
<td>100% after deductible Available only through Navitus participating pharmacies and Navitus Specialty Rx program</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Teladoc</strong></td>
<td>$45 per visit until deductible is met, then plan pays 100%</td>
<td></td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP)</strong></td>
<td></td>
<td>3 visits per issue</td>
</tr>
<tr>
<td>MEDICAL PLAN FEATURES:</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Plan Year Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per person</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Out-of-pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$5,500</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$14,300</td>
<td>Unlimited</td>
</tr>
<tr>
<td>(Includes deductible and copays)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$30 co-pay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$45 co-pay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$45 co-pay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100% no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(services as required by law as well as routine physicals and all AZLGBBT onsite screenings)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$30 co-pay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(limited to 26 visits and $40 eligible charge per visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray/Lab (in office)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$30 co-pay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$45 co-pay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>X-ray (outpatient facility)</td>
<td>$30 co-pay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Lab (outpatient facility)</td>
<td>$30 co-pay if under $500 80% after deductible if over $500</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Maternity</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100 co-pay then 80% after deductible (waived if admitted)</td>
<td>$100 co-pay then 80% after deductible (waived if admitted)</td>
</tr>
<tr>
<td>Hearing Exams &amp; Testing</td>
<td>$30 co-pay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Behavioral/Mental Health and Substance Use Disorders – Inpatient (includes residential treatment)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Behavioral/Mental Health and Substance Use Disorders – Outpatient (includes partial hospitalization)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>3 visits per issue</td>
<td></td>
</tr>
<tr>
<td>Teladoc</td>
<td>$10 copay</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to a 30-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 – generics/certain low cost brand name drugs</td>
<td>$15 co-pay</td>
<td>$30 co-pay</td>
</tr>
<tr>
<td>Tier 2 – formulary brand name drugs/certain high cost generics</td>
<td>$40 co-pay</td>
<td>$100 co-pay</td>
</tr>
<tr>
<td>Tier 3 – non-formulary drugs, both brand and generic</td>
<td>$80 co-pay</td>
<td>$200 co-pay</td>
</tr>
<tr>
<td>Preventive Drugs, Smoking Cessation drugs, and Contraceptives</td>
<td>$0 co-pay</td>
<td>$0 co-pay</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(only through Navitus Specialty Rx Program)</td>
<td>$100 co-pay</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
Wellness Overview

Preventive Screenings and Services – AZLGEBT offers a variety of onsite preventive screenings and services to eligible Medical Benefit Plan members and are covered at 100% by the Medical Plan. While the below calendar is subject to change, it offers a general overview of when the screenings are scheduled to take place.

MoveSpring

AZLGEBT will begin offering step and activity challenges through MoveSpring starting on July 1, 2020 to offer members engaging challenge modes to better support member needs through individual and competitive challenges. The MoveSpring platform will be replacing the current Fitbit platform. MoveSpring supports a variety of wearable devices including, but not limited to, the following: Fitbit, Garmin, Apple, Misfit, Withings, and more! Additionally, the subsidized device will remain in tact for the 2020-2021 Plan Year with additinoal device-options.
Livongo

AZLGEBT is excited to announce the launch of the Livongo Whole Person Solution that includes program opportunities to address pre-diabetes and weight management, diabetes management, and hypertension management. These programs will go into effective on July 1, 2020 to eligible Medical Benefit Plan members. The Livongo for Diabetes Program will be replacing the current Sweet Savings Diabetes program. Program participants currently enrolled in the Sweet Savings Diabetes program will be notified directly.

Key Elements of the Livongo Whole Person Solution include:

- **Connected Technology**: Enables real-time data and insights through the following devices:
  - Scale
  - Blood Pressure Monitor
  - Glucometer with unlimited test strips

- **Education, Lessons, and Resources**:
  - Timely and actionable health nudges and insights
  - Evidence-based curriculum and content
  - Community learning
  - 5-Day Challenges
  - Food, activity and weight tracking
  - Healthy Summary Reports
  - myStrength Self-Care Behavioral Health for issues including stress, anxiety, mindfulness, nicotine, depression, balancing emotions and more.

- **Expert Coaches**
  - Accredited and curriculum from ADA, AADE, AHA
  - Credentials that frequently include Masters of Science, Registered Dietician, Certified Diabetes Educators, etc.
  - Unlimited access
  - 24/7 support from Diabetes Response Specialists on acute high or low glucose events

More details to come to find out if you are eligible to participate!

For questions, please contact AZLGEBT@ecollinsandassociates.com.
VISION PLAN

ADMINISTERED BY VSP

SELECTION OF PROVIDERS
The vision plan allows you to utilize the vision care provider of your choice. This includes independent optometrists and ophthalmologists. There are retail chain affiliate providers available as well, for example, Costco Optical and Vision works; both with over 400 locations nationwide. Members may choose different providers for vision exam and materials purchased.

WHO IS ELIGIBLE
All benefit eligible employees who are active employees on the date the coverage is to take effect and their eligible dependents. Dependent children up to age 26.

VISION EXAM BENEFIT
Each member is entitled to a comprehensive vision exam. The exam co-pay applies as outlined in the benefits on page 21.

VISION MATERIALS BENEFIT
Each member may purchase eyewear in the form of an eyeglass frame and lenses or contact lens with this plan. Purchases are subject to benefit frequencies and co-pays.

Contact lenses may be purchased in lieu of frames and eyeglass lenses.

ANNUAL PLAN COVERS LENSES AND FRAMES OR CONTACT LENS (NOT BOTH)

Plan features include:
Frames Members may choose any frame within a provider’s collection. If the cost is greater than the plan’s benefits, the member is responsible for the difference. Members electing to utilize the vision benefit for frames and/or eyeglass lenses are not eligible to receive benefits for purchasing contact lenses.

Eyeglass Lenses Members can select new lenses of the highest quality and craftsmanship: standard plastic (CR-39 Plastic Material) single vision, bifocal and trifocal. If the cost is greater than the plan’s benefits, the member is responsible for the difference. Members electing to utilize the benefit for eyeglass lenses or frames are not eligible to receive benefits for purchasing contact lenses.

Contact Lenses: Members electing contact lenses are not eligible to receive lenses and frames under the plan during the same plan year. If the cost is greater than the plan’s benefits, the member is responsible for the difference.

Laser Vision Correction: Not a covered benefit.
**VISION CONTINUED – VISION CARE HIGHLIGHT GRID**

The below grid is a more extensive highlight of your Vision Plan with VSP:

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>VSP Network + Affiliates</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Eye Exam</strong></td>
<td>$10 Exam</td>
<td>$10 Exam</td>
</tr>
<tr>
<td><strong>Lenses (per pair)</strong></td>
<td>$10 Eye Glass Lenses or Frames*</td>
<td>$10 Eye Glass Lenses or Frames*</td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered in full</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered in full</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Covered in full</td>
<td>Up to $75</td>
</tr>
<tr>
<td>Lenticular</td>
<td>Covered in full</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Progressive</td>
<td>Covered in full</td>
<td>Up to $125</td>
</tr>
<tr>
<td><strong>Contacts</strong></td>
<td>Member cost up to $60</td>
<td>No benefit</td>
</tr>
<tr>
<td>Fit &amp; Follow Up Exams</td>
<td>Up to $150</td>
<td>Up to $150</td>
</tr>
<tr>
<td>Elective</td>
<td>Covered in full</td>
<td>Up to $210</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$150**</td>
<td>Up to $150</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>12/12/12 Based on Plan Year</td>
<td>12/12/12 Based on Plan Year</td>
</tr>
<tr>
<td><strong>Frequencies (months)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams/Lens/Frame</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Deductible applies to a complete pair of glasses or to frames, whichever is selected.

**The Costco allowance will be the wholesale equivalent.**

**Lens Options (member cost)***

<table>
<thead>
<tr>
<th><strong>Progressive Lenses</strong></th>
<th>VSP Network + Affiliates (Other than Costco)</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to provider’s contracted fee for lined trifocal lenses. The patient is responsible for the difference between the base lens and the progressive lens charge.</td>
<td>Up to lined trifocal allowance</td>
<td></td>
</tr>
<tr>
<td><strong>Std. Polycarbonate</strong></td>
<td>Covered in full for dependent children</td>
<td>No benefit</td>
</tr>
<tr>
<td>$25 adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Solid Plastic Dye</strong></td>
<td>$13</td>
<td>No benefit</td>
</tr>
<tr>
<td>(except Pink I &amp; II)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Plastic Gradient Dye</strong></td>
<td>$15</td>
<td>No benefit</td>
</tr>
<tr>
<td><strong>Photochromatic Lenses</strong></td>
<td>$27-$76</td>
<td>No benefit</td>
</tr>
<tr>
<td>(Glass &amp; Plastic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scratch Resistant Coating</strong></td>
<td>$15-$29</td>
<td>No benefit</td>
</tr>
<tr>
<td><strong>Anti-Reflective Coating</strong></td>
<td>$39-$75</td>
<td>No benefit</td>
</tr>
<tr>
<td><strong>Ultraviolet Coating</strong></td>
<td>$14</td>
<td>No benefit</td>
</tr>
</tbody>
</table>

*Lens Option member costs vary by prescription, option chosen and retail locations.

**Additional Focus® Features**

| **Contact Lenses Elective** | Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3- or 6-month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact lens fit & follow up exam allowance, the cost of the fitting and evaluation is deducted from the contact allowance. |
| **Additional Glasses** | 20% discount off the retail price on additional pairs of prescription glasses (complete pair). |
| **Frame Discount** | VSP offers a 20% discount off the remaining balance in excess of the frame allowance. |
| **Laser Vision Care** | VSP offers an average discount of 15% on LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wave front technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure. |
| **Low Vision** | With prior authorization, 75% of approved amount (up to $1,000 is covered every two years). |
DENTAL PLAN

AMERITAS will continue to be the administrator for the dental plan.

Please review the plan options carefully to select the one that best fits the needs of you and your family.

WHO IS ELIGIBLE: All benefit eligible employees who are active employees on the date the coverage is to take effect and their eligible dependents. Dependent children up to age 26.

BASIC PLAN – AMERITAS PPO PLAN

PLAN YEAR DEDUCTIBLE: AMERITAS Participating Providers: $75 per person per plan year, Non-Participating Provider: $150 per person per plan year. Deductible applies to Type 2 (Basic Restorative) and Type 3 (Major Restorative).

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Ameritas Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Benefit Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 Preventive</td>
<td>100%, no deductible</td>
<td>80%, no deductible</td>
<td>$2,000 per plan year total for participating and non-participating providers</td>
</tr>
<tr>
<td>Type 2 Basic Restorative</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Type 3 Major Restorative</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50%, no deductible</td>
<td>Not covered</td>
<td>$2,000 Lifetime Maximum</td>
</tr>
</tbody>
</table>

BUY-UP PLAN – SELECT ANY PROVIDER FOR SERVICES

PLAN YEAR DEDUCTIBLE: $75 per person per plan year. Deductible applies to Type 2 (Basic Restorative) and Type 3 (Major Restorative).

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Any Provider</th>
<th>Benefit Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 Preventative</td>
<td>100%, no deductible</td>
<td>$2,000 per plan year total for participating and non-participating providers</td>
</tr>
<tr>
<td>Type 2 Basic Restorative</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Type 3 Major Restorative</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50%, no deductible</td>
<td>$2,000 Lifetime Maximum</td>
</tr>
</tbody>
</table>
DENTAL BENEFIT DESCRIPTIONS

TYPE 1 (PREVENTIVE): Routine oral evaluations, x-rays, panoramic film, bitewing films, prophylaxis and fluoride, and palliative emergency treatment of pain.

TYPE 2 (BASIC RESTORATIVE): Basic fillings (amalgam and resin), extractions (including impacted wisdom teeth), endodontics (root canal, pulpal therapy), periodontics (treatment of gums including surgical periodontics), periodontal maintenance, oral surgery, and occlusal adjustment.

TYPE 3 (MAJOR RESTORATIVE): Space maintainers, inlays, onlays, crowns, dentures, bridges, tissue conditioning, and implants.

CLASS D (ORTHODONTIA):
Provided to dependent children under age 19.

NOTE: This is a brief description only. Certain covered expenses may be subject to an elimination period. Please refer to your summary plan document for further information including rights, benefits, exclusions, and limitations. If a non-participating provider provides services, eligible expenses are limited to usual and customary amount as determined by Ameritas.

QUESTIONS? Please contact Ameritas Group Dental at 800-487-5553.
BASIC LIFE, AD&D AND VOLUNTARY LIFE

All eligible employees are automatically covered under the Basic Life coverage paid for by Apache County. All dependents covered under the medical plan will also receive the Dependent Basic Life coverage at no additional cost.

If you have dependents that are not enrolled in the medical plan, they are not eligible to be covered under the Basic Life plan. However, you do have the option to enroll them in the Voluntary Life plan, but you, as the employee, must also elect Voluntary Life.

Basic Life Coverage:
- Employee: $50,000
- Spouse: $10,000
- Children: Live birth to age 26; $10,000

Voluntary Life is available to all benefit-eligible employees and their dependents. You may purchase additional coverage through Securian. This is offered as a One Time Guaranteed Issue opportunity. If you do not elect coverage through THIS Open Enrollment or as a New Hire, you will not have the opportunity to do so in the future, unless you experience a Qualifying Life Event. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions.

In order to elect Voluntary Life for your dependents, you the employee, must also elect Voluntary Life.

Current Active Employees – Securian is offering a One Time Only Guaranteed Issue Opportunity. You can purchase coverage for yourself up to a maximum of $300,000 without having to complete Evidence of Insurability. If you choose not to elect coverage, you will not have an opportunity to do so in the future, unless you experience a Qualifying Life Event.

You may elect or increase coverage for your lawful spouse by $10,000 up to a maximum of $50,000. In no event shall the spouse’s life insurance benefit exceed 100% of your life insurance benefit.

You may elect or increase coverage for your eligible dependent children in amounts of $10,000 or $20,000. In no event shall dependent life insurance benefit exceed 100% of your life insurance benefit.

New Hires – You can purchase coverage for yourself up to a maximum of $300,000 without having to complete Evidence of Insurability. If you choose not to elect coverage, you will not have an opportunity to do so in the future, unless you experience a Qualifying Life Event.

You may elect coverage for your lawful spouse up to a maximum of $50,000. In no event shall the spouse’s life insurance benefit exceed 100% of your life insurance benefit.

You may elect coverage for your eligible dependent children in amounts of $10,000 or $20,000. In no event shall dependent life insurance benefit exceed 100% of your life insurance benefit.

Please be sure to indicate your Beneficiary designation.
SHORT TERM DISABILITY

SHORT-TERM DISABILITY INSURANCE
If you were out of work due to an illness or injury, how would you cover the costs of daily living or the expenses associated with a disability? Short-Term Disability insurance is provided for just such an event.

Short-Term Disability is provided at no cost to all benefit-eligible employees.

Elected officials are NOT eligible for Short-Term Disability coverage.

AZLGET’s Short-Term Disability (STD) plan is designed to help bridge the gap between the date of your absence due to an illness or injury, which begins once you are absent for 45 calendar days. STD coverage provides for the payment of a weekly income benefit of 60% of your weekly base pay and is available only after you have exhausted all of your accumulated paid leave.

POLICY HIGHLIGHTS
• Benefit Amount – 60% of Salary
• Minimum Payable - $100 per week
• Benefit Duration – 135 Calendar Days
• Survivor Benefit – 30 Calendar Days

Benefits are not available if you are receiving benefits from another Group STD policy, social security disability, no-fault auto insurance, or rehabilitation income, or if your injury or illness occurs in the course of any occupation and you are eligible for Workers Compensation, or the injury or illness is self-inflicted. Please refer to your summary plan description for more details.
ONLINE ENROLLMENT

Your enrollment or changes must be completed by Friday, May 22, 2020 at 11:59 PM Arizona time. The SmartBen benefit election tool is simple to use and will make open enrollment as streamlined as possible.

Before you enroll:
1. Review and select from the available plans outlined in this guide.
2. If you are establishing a Health Savings Account or a Flexible Spending Account, you will need to know the yearly amount you wish to be deducted from your paycheck.
3. You will need to provide the social security number and date of birth for any spouse or dependent you enroll. Please do not forget to bring your dependent certification documents to your Human Resources Department. If you have not received the social security number for a newborn, enter 111-11-1111. Contact Human Resources to update the dependent’s social security number after you receive it.
4. You will need a valid personal email address to complete the online registration process. If you do not have an active email account, you may obtain one at no cost through major websites such as Yahoo, Google, or Hotmail.
5. You will need your social security number.

Online enrollment or changes:
1. Log into www.smartben.com with your Username and Password. (User name is your Social Security number with no dashes, i.e. 123456789 and password is your date of birth MMDDYYYY)
2. You will be directed to the SmartBen enrollment Benefits portal or “Your Employee Landing Page”. Click Begin Enrollment.
3. Make your elections - You will see all available benefit choices. When you click on a benefit, you will see all choices available. Simple red-light, green-light indicators let you know what you’ve completed. To turn a benefit to a green light, you must click “Continue” through all screens within the benefit election until you return back to the list of all benefit choices.
4. Continue your benefit elections until all lights are GREEN.
5. Verify Required Data: If you have not entered all required information, SmartBen will not process your enrollment. Click on each item in the Enrollment Task List and SmartBen will take you to the required page for corrections.
6. Make your corrections, click Submit, Enroll, or Save (whichever is applicable).
7. Be sure to review any “Important Information” noted on this task page and click Continue.
8. Click the Print button for a copy of your Confirmation Statement.
9. Review Your Confirmation Statement. Carefully look over your statement to ensure your benefit elections are accurate. At any time during open enrollment, you can log back in and make changes. Your due date is on the screen when you click the Enrollment Tab. Always remember to print a Confirmation Statement to serve as your confirmation of benefit elections.
Once enrolled in a medical plan, you will have access to AmeriBen’s online enrollment portal, as well as AmeriBen’s mobile application.

To Register your account:

1. To register, please visit: https://secure.myameriben.com

2. If you are a first-time user, click the “Click here to register” Button

3. Complete all fields on the Registration Page
   TIP: Be sure to enter your full legal name—if you enter a nickname, your information will not match the information in the database, and you will not be able to register

4. Create a secure password that is at least 8 characters long, and Contains at least one special character (e.g., !@#$&*)

5. Click “Submit” and accept the Terms & Conditions will appear.