Mohave County
Employee Benefit Trust

July 1, 2025 – June 30, 2026
Benefits Guide

BENEFITS OVERVIEW

Mohave County is proud to offer a comprehensive benefits package to full-time employees. The complete benefits package is briefly summarized in this booklet. You share the costs of some benefits (medical, dental and vision), and County provides other benefits at no cost to you (life, accidental death & dismemberment, short-term disability). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

TABLE OF CONTENTS

BENEFITS OFFERED

- Medical
- Dental
- Vision
- Flexible Spending Account (FSA)
- Health Savings Account (HSA)
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short-Term Disability
- Long Term Disability
- Employee Assistance Program
- Wellness program
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance

ELIGIBILITY

You and your legal dependents are eligible for benefits on the first of the month following thirty (30) days from date of hire. Eligible dependents are your spouse, children under age 26, or disabled dependents of any age that became disabled prior to age 26. Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 31 days of qualifying event.

The cost of healthcare continues to be significant. To help control healthcare costs, utilize Teladoc and urgent care instead of the emergency room (when appropriate), choose generic medications, and participate in on-site preventive screenings offered by the wellness program.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 33 for more details.

IMPORTANT DATES & INFORMATION

OPEN ENROLLMENT DATES:

Begins Monday, April 28, 2025 – Ends Friday, May 16, 2025

BENEFIT ENROLLMENT

All eligible employees wishing to make benefit election changes should do so during the Open Enrollment Period from **Monday, April 28 to Friday, May 16, 2025**. If you do not make changes, your current elections will stay in effect for the 2025-26 plan year. If enrolling in the FSA, you will need to make that election even if you are not making any other changes.

Changes MUST be made during Open Enrollment, or you must wait until you experience a Qualified Life Event.

Qualified Life Event (QLE) includes birth, death, marriage, divorce, adoption, etc. Changes MUST be made within 31 days of the QLE. Review the SPD for a full list.

The Open enrollment period is the time set aside each year for employees to review their benefit elections and decide if changes need to be made. Changes may include, but are not limited to:

- Adding or removing eligible family members
- Adding or deleting benefits
- Electing or increasing Voluntary Term Life
- Reducing or Canceling Voluntary Life Insurance
- Changing life insurance beneficiaries

Failure to complete the online enrollment process for any necessary changes effective July 01, 2025, will result in your benefits remaining the same as what is currently in place. You will not have the opportunity to make these changes until the next Open Enrollment.

DEPENDENT ELIGIBILITY & VERIFICATION:

Employees who wish to add dependents to the medical, dental, or vision plans for the 2025-26 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, and an additional document dated within the last 60 days (mortgage statement, lease agreement. auto loan/gas/electric bill, etc., birth certificates, 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. Please see Human Resources for a full list of acceptable documents to show Dependent Eligibility.

CONTRIBUTIONS

Rates below are per pay period.
Contributions are taken 24 of the 26 annual pay periods.

2025-2026 Rates and Contributions – Medical: Meritain

EPO	County	Employee
Employee	$356.84	$51.82
Employee + Spouse	$681.98	$157.15
Employee + Child(ren)	$600.57	$138.69
Employee + Family	$984.35	$225.89

HDHP	County	Employee
Employee	$303.35	$44.26
Employee + Spouse	$572.10	$132.44
Employee + Child(ren)	$507.71	$117.79
Employee + Family	$814.32	$187.62

2025-2026 Rates and Contributions – Dental: Ameritas

LOW	County	Employee
Employee	$4.04	$4.94
Employee + Spouse	$8.12	$9.993
Employee + Child(ren)	$7.36	$8.99
Employee + Family	$11.70	$14.29

HIGH	County	Employee
Employee	$9.08	$11.10
Employee + Spouse	$18.23	$22.28
Employee + Child(ren)	$18.06	$22.08
Employee + Family	$27.29	$33.35

2025-2026 Rates and Contributions – Vision: Ameritas (EyeMed or VSP)

EyeMed	County	Employee
Employee	$0	$3.22
Employee + Spouse	$0	$6.11
Employee + Child(ren)	$0	$6.42
Employee + Family	$0	$9.44

VSP	County	Employee
Employee	$0	$3.22
Employee + Spouse	$0	$6.11
Employee + Child(ren)	$0	$6.42
Employee + Family	$0	$9.44

MEDICAL BENEFITS

Administered by Meritain and BCBSAZ in Arizona & Aetna in 49 Other States

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	EPO PLAN	HIGH-DEDUCTIBLE PLAN
BENEFIT	Member Pays:	Member Pays:
Calendar Year Deductible* **July 01, 2025 – December 31, 2025**	$1,200 per Person	$3,250 per Person $6,500 per Family
Calendar Year Out-of-Pocket Maximum** **July 01, 2025 – December 31, 2025**	$6,300 per Person $12,700 per Family	$3,250 per Person $6,500 per Family
Calendar Year Deductible* **January 01, 2026 – June 30, 2026**	$1,200 per Person	$3,300 per Person $6,600 per Family
Calendar Year Out-of-Pocket Maximum** **January 01, 2026 – June 30, 2026**	$6,300 per Person $12,700 per Family	$3,300 per Person $6,600 per Family
Physician Office Visits/Surgeries		
- Primary Care Physician/Specialist	$30 / $50 Copay	100% Covered after Deductible
- Teladoc	$0 Copay	$56 Per Visit Until Deductible is Met Then Paid 100%
Preventive Services/Routine Care		
- Required by Health Care Reform	$0 Copay - Deductible Waived	100% (Deductible Waived)
- Over & Above Health Care Reform	$30 / $50 Copay	100% (Deductible Waived)
Diagnostic Testing - X-Ray And Lab Services Performed:		
- Inside a Physician's Office	Paid under Physician's Office Visit	100% Covered after Deductible
- Outside of Physician's Office or Hospital		
- In a Hospital	20% after Deductible	100% Covered after Deductible
Urgent Care	$75 Copay	100% Covered after Deductible
Emergency Room Services	$200 Copay, then Deductible, then 20% (Waived if Admitted)	100% Covered after Deductible
Inpatient Hospital Services	20% after Deductible	100% Covered after Deductible
Outpatient Hospital Services	20% after Deductible	100% Covered after Deductible
Mental Health/Substance Use Disorders		
- Inpatient	20% after Deductible	100% Covered after Deductible
- Outpatient	$30 Copay	100% Covered after Deductible

*** The Deductible must be met on the High-Deductible Plan before the Plan pays any benefits with the exception of preventive services and medications required by Health Care Reform laws.**

**** The EPO Out-of-Pocket Maximum includes the Medical Deductible, Copays and Coinsurance.**

The High-Deductible Plan's Out-of-Pocket Maximum is the same as the Deductible, therefore once the Deductible has been met all eligible services are paid by the Plan at 100%.

MEDICAL BENEFITS

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Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

ARIZONA MEDICAL NETWORK

BlueCross BlueShield of Arizona

It's important to verify providers are in your plan's network before you see them. If you have a HDHP, providers who are not in your plan's network will cost you more. If you have an EPO plan, providers who are not in your plan's network will not be covered by your plan.
Log in to www.azblue.com to find a provider in your network.

1. Click "Find Care" then "Browse the Network",
2. Type of Coverage is "Employer Provided", Type of Provider is "Medical" and Network is "CHS".
3. Choose your location and search

49 OTHER STATES MEDICAL NETWORK

aetna

It's important to verify providers are in your plan's network before you see them. If you have a HDHP, providers who are not in your plan's network will cost you more. If you have an EPO plan, providers who are not in your plan's network will not be covered by your plan.
Log in to www.aetna.com/docfind/custom/mymeritain.com to find a provider in your network.

1. Click "Aetna.com" then "Find a Doctor
2. Type of Coverage is "Point of Service Choice II"
3. Choose your location and search

After the doctor's visit, in-network providers send the price adjustment request to BCBSAZ or Aetna. BCBSAZ/Aetna will grant a price reduction based on the agreement with the provider. Once repriced, the claim is sent to Meritain for final processing. Meritain reviews the services billed to verify charges are payable for covered services. The provider will receive payment, both the provider and participant receive an Explanation of Benefits (EOB) explaining how the claim was paid. For any claim or plan questions, please login into www.meritain.com or call Meritain at 866-300-8449.

MEDICAL CLAIMS ADMINSTRATION

Administered by Meritain

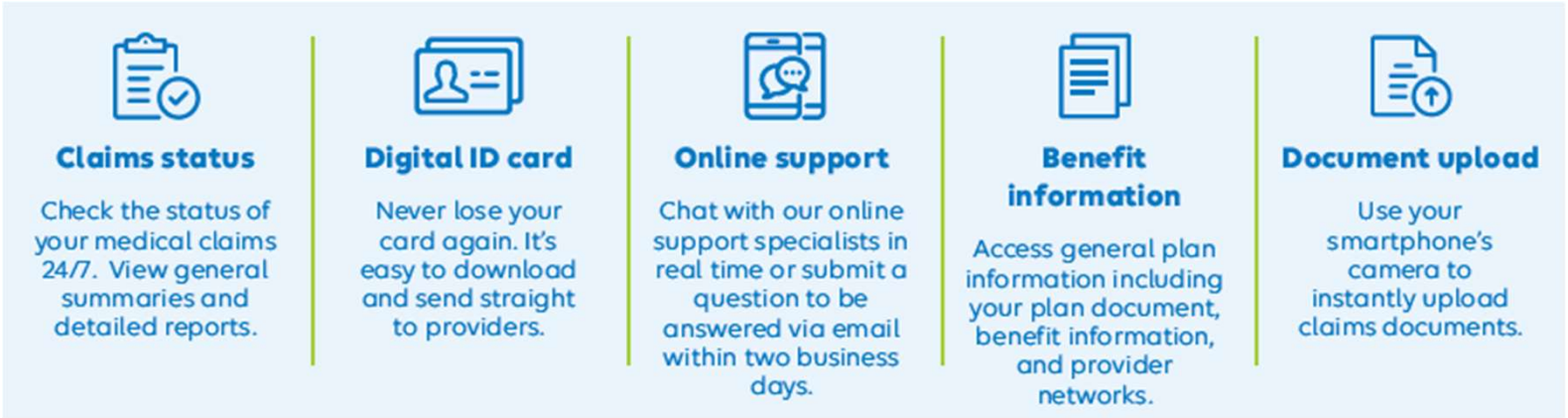
Meritain.com
Your resource for claims, benefits, and eligibility information

To register online:

1. Visit meritain.com
2. If you are a first-time user, select the Click here to register button.
3. Register with your member ID or last four digits of your Social Security Number
4. Complete all fields on the registration page. 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.
5. Choose Submit and accept the *Terms and Conditions* that will appear.

To register on meritain.com

1. Download the Meritain Mobile on your iOS or Android device.
2. Open the app.
3. If you have previously logged in to meritain.com, use the same username and password for the Mobile. If you have not previously created a user profile, select Create an Account on the homepage and follow the instructions.
4. Read and accept the licensing agreement.
5. Confirm your identity.



Telemedicine
General Medicine - 24/7/365

Administered by Teladoc

Avoid expensive emergency room visits by using Teladoc. The average cost of an E.R. visit is $2,283. You may be responsible for a copayment, deductible and coinsurance depending on which plan you are enrolled in so it may cost you between $500 to $2,283. Compare this to $56 for HDHP members or $0 for EPO members.

Discover the convenience, comfort, and savings of Teladoc

If you don't have a regular doctor, or if your primary care provider isn't available, you can visit with a board-certified doctor in the privacy and comfort of home. See a doctor, counselor, or psychiatrist from your phone, computer, or tablet. So, you can get the care you need—from wherever you are. Plus, Teladoc visits often cost less than an urgent care visit.

What services are offered?

Medical

Get treated for minor injuries and illnesses and non-emergency health issues like cold and flu symptoms, fevers, rashes, and stomach bugs. Doctors can also prescribe medications from your pharmacy of choice, if needed.

Allergies
Bronchitis
Cold/flu
Headaches/migraines
Eye/ear infection
Rash/skin infections
Sinus infections
Stomachache/diarrhea
Urinary tract infections
Many other conditions

TELADOC™

	EPO	HDHP
General Health	$0 copay	$56 (100% after deductible)

Telemedicine Behavioral Health

Administered by Teladoc

Make an appointment 7 days a week from 7:00 a.m. to 9:00 p.m. local time

Appointment confirmed within 72 hours.

Teladoc Health behavioral health experts provide support for:

- Anxiety.
- Depression.
- Stress.
- Mood swings.
- Not feeling like yourself.
- Trauma and PTSD.
- Relationship conflicts.
- Medication management.

Expert guidance and action planning

When 16 million Americans live with major depression[1], it's imperative members get the care and treatment they need. Teladoc Health offers an integrated care model where members can navigate and manage mental health issues from all aspects of care and levels of complexity. It provides:

- Quick access to treatment from qualified, licensed practitioners.
- Guidance through the system with an action plan for next steps.
- Expert second opinions on their diagnosis and treatment plan.

	EPO	HDHP
Counseling	$15 copay	$90 (100% after deductible)
Psychiatry	$25 copay	$100-$215 (100% after deductible)

69% Members with depression showed improvement in symptoms in two visits

72% Members with anxiety showed improvement in symptoms in two visits

Depression Anxiety Stress Scales (DASS) scores symptom reduction

-32% Depression

-31% Anxiety

-20% Stress

Precertification, Case Management and Patient Advocacy Program

Administered by American Health Group (AHG)

Precertification

Pre-certification is an evaluation conducted by American Health Group, the Medical Management Administrator, in conjunction with the attending physician, to determine medical necessity and reasonableness of a plan participant's course of treatment

Failure to comply with the pre-certification requirements may result in a $300 penalty per occurrence on Covered Expenses

MCEBT Medical Benefit Plan requires pre-certification of certain services, including the following:

- Chemotherapy
- Outpatient Surgical Procedures
- Infusion/Injectable Medications in excess of $1,000 that are administered in all settings
- Outpatient Diagnostic Tests and Imaging
- Injectable medications in excess of $1,000 settings administered in a Physician's office or in conjunction with home health services
- Inpatient admissions
    - If Inpatient admission is with respect to an Emergency Medical Condition, you must notify the Medical Management Program Administrator within 48 hours
- Occupational therapy
- Physical therapy
- Psychological and neuropsychological testing
- Radiation therapy
- Speech therapy

Please visit the Summary Plan Document for more information

Case Management

Services designed to help manage the care of plan participants who have complex, special, or extended care illnesses or injuries. Members who may be appropriate to receive services are contacted by AHG directly and are offered assistance in navigating their treatment. If you are dealing with a complex medical diagnosis or treatment plan and would like to receive the assistance of a nurse case manager, please reach out to AHG.

American Health Group (AHG)

1.800.847.7605 / 602.265.3800

info@amhealthgroup.com

BENEFIT CHANGES
EFFECTIVE JULY 01, 2025

ADMINISTRATIVE

Remove Precertification for Hospice

MEDICAL – HDHP

Discontinue Teladoc & Telemedicine $0 Member Cost Share effective July 01, 2025.
Member Cost Share will apply per Schedule or Benefits

WELLNESS

Replace Livongo Program with Digbi Health
Eliminate Navigate Wellness Portal

BENEFIT CHANGES
EFFECTIVE JANUARY 01, 2026

MEDICAL/PRESCRIPTION

High-Deductible Health Plan

Increase Out of Pocket Maximum:
- Single - $3,250 to $3,300
- Family - $6,500 to $6,600

CHOOSING THE RIGHT CARE

Quick reference guide for medical treatment options:

Care Center	Hours	Your Relative Cost *	Description
Meritain Customer Care	6 a.m. - 6 p.m. MT	No additional cost to you.	Assistance with finding care, benefits questions, claims status, digital ID cards, and any other questions that arise concerning care. **866-300-8449**
American Health Group Case or Health Management RN	Monday-Friday 8 am - 5 pm	No additional cost to you	Assistance in navigating the healthcare system. We help you understand your condition, answer your health-related questions, facilitate quality care, and help you manage your healthcare costs. **800-847-7605**
Curalinc Employee Assistance Program	24 hours, 7 days a week	No additional cost to you	Curalinc offers 6 visits per issue per year **888-881-5462**
Doctor's Office	Office hours vary - need an appointment	Usually lower out-of-pocket costs to you than urgent care	It is important that you establish care with a primary care provider to manage your care. Your provider's office is generally the best place to go for non-emergency care such as health exams, colds, flu, sore throats, and minor injuries.
Teladoc	24 hours, 7 days a week	Usually lower out-of-pocket costs to you than urgent care	24/7 access to a provider via phone and online video consultations. Can be accessed from anywhere you are. Average call back time is under 10 minutes. Provides services for problems such as colds, flu, bronchitis, allergies, ear/sinus/respiratory infections, urinary tract infections, dermatologic conditions **1-800-TELADOC** www.teladoc.com
Teladoc	7 days a week 7:00 a.m.-9:00 p.m. Local Time	Usually comparable In-Person Mental Health Services	Access to a Behavioral Health Provider via phone and online video consultations. Appointment confirmed within 72 hours, Provides services for anxiety, depression, stress, mood swings, relationship conflict, not feeling like yourself, trauma, etc. **1-800-TELADOC** www.teladoc.com

CHOOSING THE RIGHT CARE

Quick reference guide for medical treatment options:

Care Center	Hours	Your Relative Cost *	Description
Retail Health Clinic	Similar to Retail Store hours	Usually lower out-of-pocket costs to you than urgent care	Walk-in clinics are often located in stores or pharmacies to provide convenient, low-cost treatment for minor medical problems such as ear infections, colds/flu, bronchitis, and some vaccinations.
Urgent Care Provider	Generally, includes evenings, weekends, and holidays	Usually lower out-of-pocket costs to you than an ER visit	Urgent Care Centers can provide care when your doctor is not available for non-emergency services, but when immediate care is needed for conditions such as sprains, fevers, minor cuts, and injuries.
Emergency Room (ER)	24 hours, 7 days a week	Highest out-of-pocket cost to you	For medical emergencies, call 911 or local emergency services first. Any life threatening or disabling condition, sudden/unexplained loss of consciousness, chest pain, numbness in face/arm/leg, difficulty speaking, severe shortness of breath, high fever with stiff neck/ confusion or difficulty breathing, coughing up or vomiting blood, cut or wound that won't stop bleeding, major injuries, possible broken bones.

**Relative costs described are for in-network providers. Your costs for out-of-network providers may be significantly higher.*

*** Preventive services are covered with no cost sharing when delivered by in-network providers. Certain services have age-specific requirements.*

If you do not currently have a Primary Care Provider, we can assist you with finding an in-network provider by calling Meritain Customer Service team at **866-300-8449**.

HOW THE PLANS WORK

Both plans use the Blue Cross Blue Shield of Arizona network and cover 100% of the cost for preventive care services like calendar year physicals and routine immunizations. The way you pay for care is different with each plan.

With the HDHP, you pay the full negotiated cost for medical services and prescription drugs until you meet your calendar year deductible. After that, the plan pays for 100% of your claims for the rest of the year.

The EPO plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your calendar year out-of-pocket maximum.

	HDHP Plan	EPO Plan
Monthly Cost for Coverage **Employee** **Employee + Spouse** **Employee + Child(ren)** **Employee + Family**	 $88.52 $264.88 $235.57 $375.23	 $103.64 $314.30 $277.37 $451.77
Deductible (Individual / Family)	$3,250 / $6,500	$1,200
Out-of-pocket Maximum (Individual / Family)	$3,250 / $6,500	$6,300 / $12,700
Spending Account Options	Health savings account (HSA) *or* Health Care FSA Dependent care FSA	Health care FSA Dependent care FSA

PAYING FOR HEALTH CARE

Mohave County offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose. Please see page 20 for more detail.

	HSA	FSA
What medical plan can I choose?	HDHP	HDHP or EPO plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)
When can I use the funds?	Funds are available as you contribute to the account	All the funds you elect for the year are available on the first payday after January 1
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	No, you will lose any funds remaining in your account at the end of the year, unless your plan has a grace period or carryover
How do I pay for eligible expenses?	With your HSA Bank debit card (You can also submit claims for reimbursement online at www.healthequity.com)	With your FSA debit card (You can also submit claims for reimbursement online at www.healthequity.com)
How much can I contribute each year?	$4,300 for individual coverage or $8,550 for family coverage If you are age 55+, you can contribute an additional $1,000 annually	You can contribute up to $3,300 annually.
Can my employer contribute?	The employer does not contribute to the HSA account.	The employer does not contribute to the FSA account.
Can I change my contributions throughout the year?	Yes, please contact your Human Resources Department	No, unless you have a qualifying life event

PHARMACY BENEFITS

Administered by Navitus

	HDHP		EPO PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
PHARMACY			Preferred Network	
Expanded Preventive List Medications	Formulary medications appearing on the Expanded Preventive list are covered with $0 member cost-sharing. This list is updated periodically by Navitus. Log into your Navitus account to review the list. www.Navitus.com.		Preventive medications required by law are covered at $0 member cost-sharing.	
Retail (up to 30 days)	Generic Drugs 100% after Deductible Preferred Brand Name Drugs 100% after Deductible Non-Preferred Brand Name Drugs 100% after Deductible		Generics $15 copay Preferred Brand Name $40 copay Non-Preferred Brand Name $80 copay	
Mail Order (90 days)	Generic Drugs 100% after Deductible Preferred Brand Name Drugs 100% after Deductible Non-Preferred Brand Name Drugs 100% after Deductible		Generics $30 copay Preferred Brand Name $100 copay Non-Preferred Brand Name $240 copay	
Specialty Drugs 3**0 Day/90 Day**	100% after Deductible		$100 copay/$300 Copay	
			Non-preferred Pharmacy (CVS and Walgreens) copays are higher.	

Formulary Facts

A formulary is a comprehensive list of preferred drugs chosen based on quality and efficacy by a committee of physicians and pharmacists. The drug formulary serves as a guide for the provider community by identifying drugs which are covered. It is updated regularly and includes both generic and brand name medications. You can find the Mohave County Employee Benefit Trust (MCEBT) formulary on the Navitus member portal. Also included is information about which drugs need prior authorization or have quantity limits.

Preventative Medications

Certain preventive care prescription drugs mandated under Healthcare reform are covered at 100% with no participant cost-sharing when obtained in-network. An expanded list of 100% covered preventive medications is available to HDHP members.

Customer Service

You can find additional information about your prescription drug plan at www.navitus.com or contact Navitus Customer Service at 855.673.6504. Both resources are available 24 hours a day, 7 days a week.

Mail Order

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

Step 1 – Register online at www.costco.com/home-delivery. Select “Sign In/Register” to create an account. Enter all the required information.

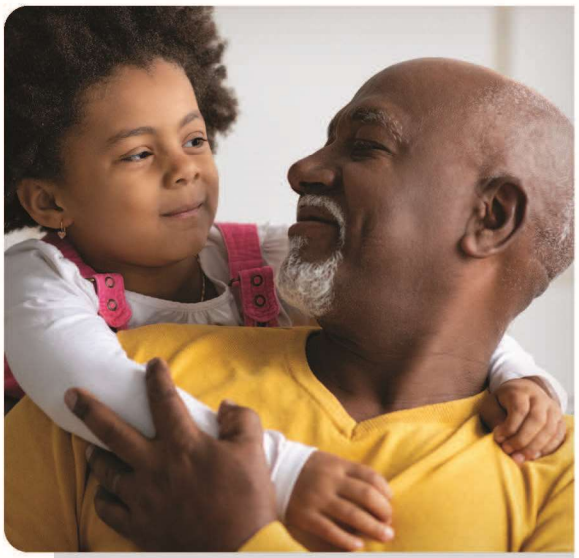
Step 2 – Fill your prescription. Request your new prescription online at www.costco.com/home-delivery. Your provider can provide the prescription by calling 800.607.6861 or e-prescribing it to Costco.

Step 3 – Obtain refills online at www.costco.com/home-delivery, or by calling 800.607.6861 or by enrolling in the auto refill program.

NAVITUS

Rx Saving Tips

3 Ways to Lower Your Drug Costs



One out of every four adults taking a prescription finds it difficult to afford their medication. Even if you don't have difficulty paying for a drug, it's always nice to have a little extra money in your pocket.

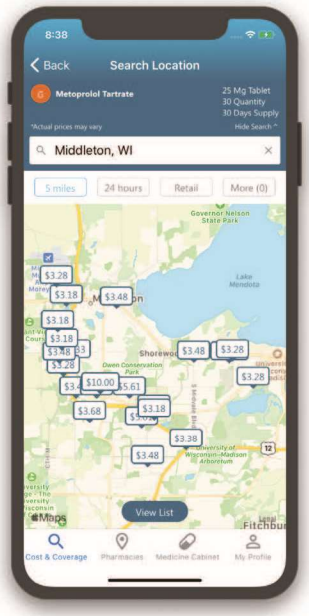
Here are a few strategies to help you save on your prescriptions:

1. EXPLORE YOUR PHARMACY BENEFIT

The Navitus member portal and mobile app are easy ways to help you make the most of your pharmacy benefit. Once you are registered, you can:

- Check prices at your network pharmacies
- View your member ID card
- Access your medication history

Go to navitus.com/members to register for the portal. You can also use the download the mobile app[1] for access on the go.



2. CONSIDER A LESS EXPENSIVE GENERIC

Did you know that brand name drugs can be more than 20X more expensive that the generic equavalent? Generics are just as effective as brand-name drugs, have the same active ingredients and go through the same rigorous U.S. Food and Drug Administration (FDA) testing. If you are taking a brand drug, ask your provider if a generic is appropriate.

3. TAKE ADVANTAGE OF CONVENIENT 90-DAY REFILLS

Ask your prescriber if your maintenance medication can be filled every 90 days instead of every 30 days. Not only will you make fewer trips to the pharmacy, in many cases, you will save money, too. Typically, 90-day refills can be filled either at your retail pharmacy or by mail order.[2] Check your plan details on Navitus' member portal or your plan's website.

Download on the App Store

GET IT ON Google Play

1. The mobile app, and individual features of the app, may not be available for all benefit plans managed by Navitus, or for every member of each plan. Please refer to your plan for more information. Mobile app registration is simple and secure and may require your member ID. The app is available to iOS and Android users. You must be 18 years or older and currently covered under Navitus' pharmacy benefit plan. Hover your phone's camera over the code to download the app. For help registering, contact Customer Care: 844-268-9789. Open 24 hours a day, 7 days a week.
2. Please refer to your plan description to see if a mail order program is available to you.

* This QR code may identify your IP/device information. However, your personal and health information is strictly confidential and will not be captured.

DENTAL BENEFITS

Administered by Ameritas

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Ameritas dental benefit plan.

LOW PLAN	
Calendar Year Deductible (Individual / Family)	$100/$300
Annual Benefit Maximum	$2,000 Per Covered Person
Preventive Dental Services (cleanings, exams, x-rays)	80%, no deductible
Basic Dental Services (fillings, root canal therapy, oral surgery)	80% after deductible
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50% after deductible
Orthodontia Services (covered to age 19)	None

HIGH PLAN	
Calendar Year Deductible (Individual / Family)	$50/$150
Annual Benefit Maximum	$2,000
Preventive Dental Services (cleanings, exams, x-rays)	$0, no deductible
Basic Dental Services (fillings, root canal therapy, oral surgery)	80% after deductible
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50% after deductible
Orthodontia Services (covered to age 19)	50%, no deductible $1,500 lifetime maximum

Finding a Network Dentist

1. Go to www.ameritas.com and click Find a Health Provider in the top menu.
2. Select Find a Network Dental Provider Online.
3. Enter your search criteria and choose Classic (EPO) network. If necessary, you can also narrow the results by name, distance, or specialty.
4. You may also call 800-487-5553 for assistance.

DENTAL BENEFITS

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 and adult orthodontia

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.

VISION BENEFITS

Voluntary Employee Paid Benefit

Administered by VSP/EyeMed

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Deductibles	**EyeMed/VSP Network + Affiliates** $10 Exam $25 Eye Glass Lenses or Frames*
Annual Eye Exam	Covered in full
Lenses (per pair)	
Single Vision	Covered in full
Bifocal	Covered in full
Trifocal	Covered in full
Lenticular	Covered in full
Progressive	See lens options
Contacts	
Fit & Follow Up Exams	Member cost up to $60
Elective	Up to $180
Medically Necessary	Covered in full
Frames	$180**
Frequencies (months)	
Exams/Lens/Frame	12/12/12 Based on Plan Year

Find a Network Provider

1. Register and log in to the member vision portal at www.VSP.com
2. Select Find A Doctor. You may search by location, office, or doctor.
3. Book your appointment!

Deductible applies to a complete pair of glasses or to frames, whichever is selected. **The Costco allowance will be the wholesale equivalent.

	EyeMed/VSP Network + Affiliates (Other than Costco)
Progressive Lenses	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.
Std. Polycarbonate	Covered in full for dependent children
Solid Plastic Dye	$25 adults $13
Plastic Gradient Dye	(except Pink I & II)
Photochromatic Lenses	$15
(Glass & Plastic)	$27-$76
Scratch Resistant Coating	
Anti-Reflective Coating	$15-$29
Ultraviolet Coating	$39-$75 $14

Find a Network Provider

1. Register and log in to the member vision portal at www.EyeMed.com
2. Select Find A Doctor. You may search by location, office, or doctor.
3. Book your appointment!

SPENDING ACCOUNTS

HEALTH SAVINGS ACCOUNT (HSA)

Administered by HSA Bank

A Health Savings Account (HSA) provides you with a tax advantage that can help you pay for certain expenses on a pre- tax basis. As an eligible employee, you agree to set aside a portion of your pre-tax salary in a HSA, and that money is deducted from your paycheck over the course of the plan year.

Contributions to your HSA reduce your taxable income, and qualified medical expenses are never taxed. All money set aside in an HSA grows tax-deferred until age 65, when funds can be withdrawn for any non-medical purpose at ordinary tax rates, or tax-free when used for qualified medical expenses.

Note: If you are enrolled in a non-HDHP, Medicare, Medicaid or Tricare, General Purpose Health Flexible Spending Account, Health Reimbursement Arrangement or claimed as someone else's tax dependent, by law you are not allowed to contribute to an HSA.

Individual Coverage Contribution Maximum	$4,300
Individual Coverage Contribution Maximum	$8,550

- Contribution maxes are $179.17 per pay period for individual coverage, and up to $356.25 per pay period for family coverage towards the employee's Health Savings Account (HSA). These span over 24 pay periods, Contributions are typically available approximately 5-7 business days after each pay date.
- HSA accounts operate on a calendar-year basis. A participant can elect to contribute the maximum amount from July 1, 2025- December 31, 2025; however, to avoid tax issues, the individual must remain on the Health Savings Plan/HDHP through the full plan year following elections.
- A monthly maintenance fee of $1.75 is charged if balance is less than $3,000.
- HSA Bank 800-357-6246 or www.hsabank.com

FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by Meritain

You can save money on your healthcare and/or dependent day care expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

You must enroll in the FSA program within 30 days of your eligibility date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more.

Healthcare Contribution Limit	$3,300
Dependent Care Spending Limit	$5,000

LIFE INSURANCE BENEFITS

Administered by Ochs, A Securian Financial Company

The County provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance at no cost to eligible employees. All benefit eligible employees are automatically enrolled in this coverage. Employees also have an option to enroll in Voluntary Term Life.

Basic Life Coverage - 100% employer paid & automatically enrolled		
Basic term life	**$50,000**	✓ Includes a matching AD&D benefit ✓ Includes a Line of Duty benefit
Supplemental Life Coverage - 100% employee paid – Employee and Spouse Subject to Evidence of Insurability		
Supplemental term life	Elect in **$10,000** increments Maximum **$300,000**	
Spouse term life	Elect in **$10,000** increments Maximum **$50,000**	✓ Cannot exceed 100% of employee's basic & supplemental coverage combined ✓ Employee must be enrolled in supplemental life to elect spouse life
Child term life	Elect **$10,000** or **$20,000**	✓ Includes 1st newborn child benefit ✓ Employee must be enrolled in supplemental life to elect child life ✓ Available to elect without health questions each annual enrollment

If your spouse or child is eligible for employee coverage, they cannot also be covered as a dependent. Only one employee may cover a dependent child. It is the employee's responsibility to notify their employer when dependents are no longer eligible.

Monthly Cost:

	Rates	
Coverage	Rate per $1,000 per month	
Basic Active Life	$0.130	
Basic Active AD&D	$0.030	
Employee/Spouse Supplemental Life	Age	Rate
	Under 25	$0.06
	25 – 29	$0.06
	30 – 34	$0.08
	35 – 39	$0.10
	40 – 44	$0.15
	45 – 49	$0.23
	50 – 54	$0.36
	55 – 59	$0.54
	60 – 64	$0.91
	65 – 69	$1.67
	70 – 74	$2.44
	75*	$4.05
Child Life	$0.20	

Child Life	
$10,000	**$20,000**
$2.00	$4.00

One premium covers all eligible children from live birth to age 26

Keep Your Beneficiaries Up to Date

- ❖ Make sure to keep this information updated so your benefit is paid according to your wishes.
- ❖ This may be done in the PlanSource Portal.

* Please see the full certificate for additional information, options, and restrictions.

GROUP LIFE INSURANCE PROGRAM

Guaranteed Issue & Evidence of Insurability (EOI)

Life Insurance Coverage Available

No Health Questions!

There are certain times in which employees can enroll for coverage Guaranteed Issue. Guaranteed Issue means that coverage can be elected without answering health questions, otherwise known as Evidence of Insurability (EOI). Below is a breakdown of when coverage is Guaranteed Issue and when EOI and medical underwriting will be required.

Employee

NO HEALTH QUESTIONS	REQUIRES HEALTH QUESTIONS (EOI)
✓ **Newly hired employees:** Up to **$300,000** in **$10,000** increments ✓ **Qualifying Life Events:** Up to **$300,000** in **$10,000** increments	✓ **Annual Enrollment:** **All elections and increases**

Spouse

NO HEALTH QUESTIONS	REQUIRES HEALTH QUESTIONS (EOI)
✓ **Newly hired employees:** Up to **$50,000** in **$5,000** increments ✓ **Qualifying Life Events:** Up to **$50,000** in **$10,000** increments	✓ **Annual Enrollment:** **All elections and increases**

Child

NO HEALTH QUESTIONS
✓ **Newly hired employees:** **All coverage** ✓ **Annual enrollment:** **All coverage** ✓ **Qualifying Life Events:** **All coverage**

Questions? Contact Ochs. Email: ochs@ochsinc.com Phone: 800-392-7295

Rev. 3-2024

DISABILITY INSURANCE

DISABILITY INSURANCE

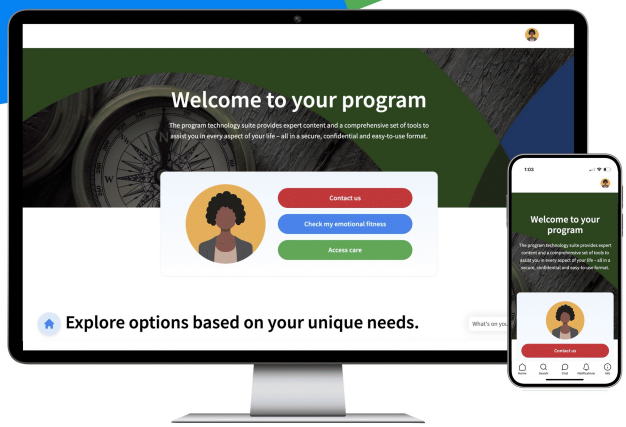
The County also provides short-term disability coverage through Madison National. For employees contributing to the Arizona State Retirement System through Mohave County, they and the County contribute to long-term disability coverage each paycheck. This benefit replaces a portion of your income if you become disabled and are unable to work.

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
Short-term Disability	You receive 60% of Predisability Earnings plus shift differential up to a Maximum Weekly Benefit of $2,200. Benefits begin after 30 calendar days and may continue for up to 150 calendar or until Long Term Disability Benefits commence, whichever comes first.	MOHAVE COUNTY
Long-term Disability	You receive 66 2/3% of your income. Benefits begin when short-term disability benefits end and continue until you reach the Social Security Normal Retirement Age. Please visit this guide for more information: AZASRS Long-Term Disability	MOHAVE COUNTY and EMPLOYEE (Shared Contribution)

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

EMPLOYEE ASSISTANCE PROGRAM

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



In-the-moment support

Reach a licensed clinician by phone 24/7/365 when you call for assistance.

Short-term counseling

Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.

Coaching

Get assistance from a Coach to boost your emotional fitness, learn healthy habits, establish new routines, build your resilience and more.

Work-life benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.

Confidentiality

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

Your web portal and mobile app

- Create a personal profile to quickly access support from a licensed clinician
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos

Start with Mental Health Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator assessment. You'll instantly receive personalized guidance to access care and support.

supportlinc EMPLOYEE ASSISTANCE

Download the mobile app today!

1-888-881-5462

supportlinc.com
group code: **mcebt**

WELLBEING PROGRAM AND PREVENTIVE SCREENINGS

Administered by Gallagher Benefit Services

The comprehensive Wellness Program is available to all employees, spouses, and dependents 18+ enrolled in the medical plan. The Wellness Program focuses on early detection, healthy habit tracking, and health education. Below is a brief overview of major program offering.

As a part of the MCEBT Wellness Program, preventive screenings and services are brought onsite to provide members a convenient and timely way to protect their health. Preventive screenings and services include the following:

Health Risk Assessment: Provides a snapshot of risk factors to development of chronic conditions, such as cardiovascular disease and diabetes.

Biometrics include height, weight, BMI, blood pressure, and waist circumference. Venipuncture blood draw includes Total Cholesterol, HDL, LDL, Triglycerides, Glucose, Kidney and Liver Function, Calcium, Electrolytes, PSA, and more!

Skin Cancer Screenings: Comprehensive, full body skin screening provided onsite or in a mobile unit to detect a range of skin abnormalities.

Healthy Heart Blood Draw: Checks blood pressure, blood glucose, total cholesterol, and LDL & HDL cholesterol levels.

Cardiac and Organ Screenings: Unique screening brought onsite that provides the following tests:

Cardiac screening: includes ultrasounds looking for blockages, reduced blood flow and rupture of the Carotid Artery, Peripheral Arteries, and Abdominal Aorta.

Organ screening: includes ultrasounds looking for any abnormality including nodules, cysts or changes in the organs' structure through ultrasounds of the kidneys, liver, gallbladder, and thyroid.

Bone Density test. Spirometry test.

Retinopathy Screening: Takes a quick snapshot of the inner eye to detect early signs of health problems based on the appearance of blood vessels and other structures.

Mammograms: Routine mammography screenings are offered onsite in a mobile unit for women aged 40 and older annually. A one-time baseline screening mammogram is recommended for women aged 35-39.

Flu vaccinations: Quadrivalent flu vaccinations is offered onsite to minimize risk of flu-related illness to create a more productive environment throughout flu season.

Preventive screenings and services brought onsite through the MCEBT Wellness Program are covered at 100% for Employees and dependents covered on the MCEBT Medical Benefit Plan.

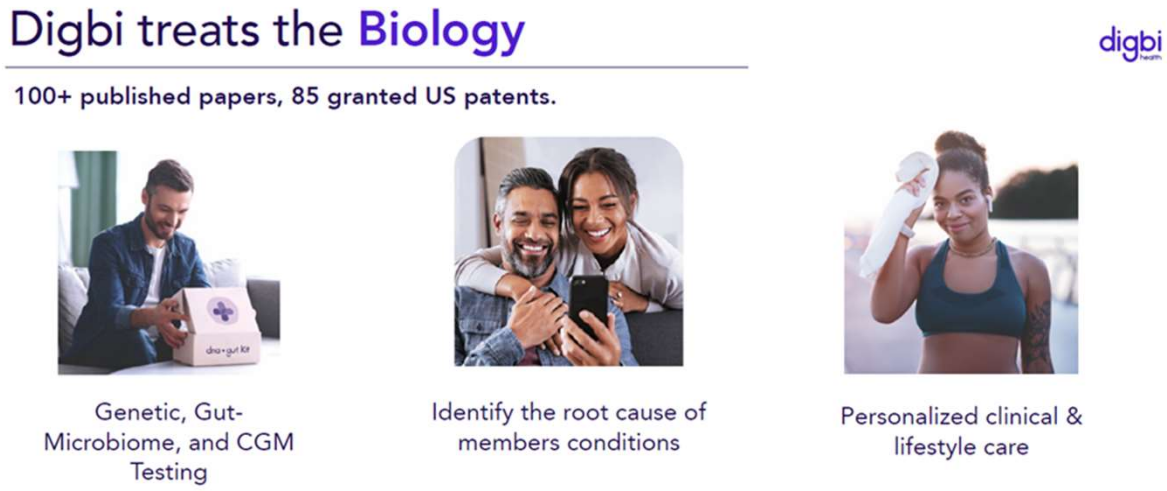
For questions, please reach out to your Human Resources Department.

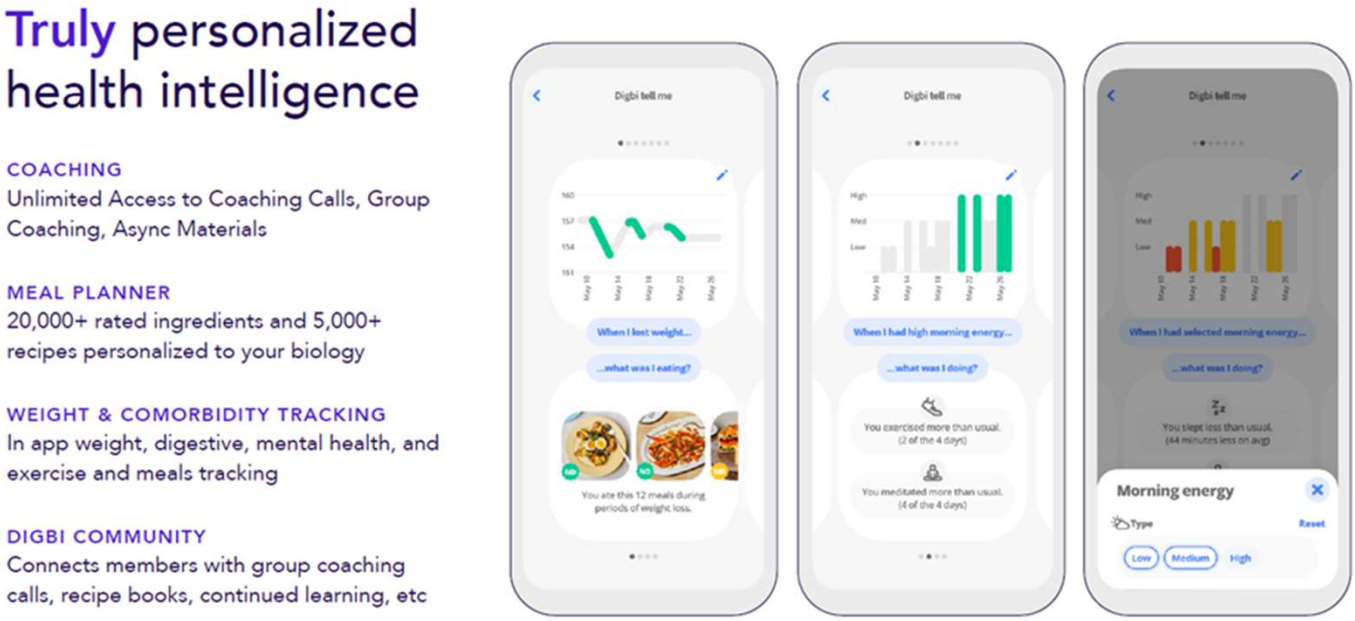
WELLBEING PROGRAM

Administered by Gallagher Benefit Services

Digbi Health

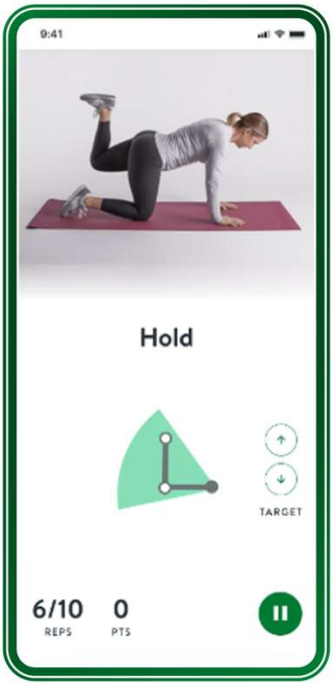
Digbi, a much more comprehensive and holistic approach to care! Digbi uses Precision Biology to treat over 400 different conditions, including diabetes, digestive health and obesity. Through a combination of gut tests, genetic tests and continuous glucose monitors, Digbi physicians create a personalized approach to care that is based on the user's unique biology. This intentional and specific approach to care is incredibly impactful as it is based on *your* specific needs.





Hinge Health

Conquer back and joint pain without drugs or surgery



We provide all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your needs, technology for instant feedback in the app, personal coach and physical therapist. Best of all, **it's free** — 100% covered by Mohave County for you and eligible family members.

Sign up today for help with any of the following:

- **Conquer pain or limited movement**
- **Recover from a past injury**
- **Reduce stiffness in achy joints**

Join for your **back, knee, hip, neck, or shoulder.** On average, participants cut their pain as much as 68%*!

Scan the QR code to learn more or apply at
hinge.health/mohavecounty
or call (855) 902-2777

Employees and dependents 18+ enrolled in the Mohave County medical plan through Meritain are eligible.
*Participants with chronic knee and back pain after 12 weeks. Bailey, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. JMIR. (2020).

VOLUNTARY BENEFITS

While you can't predict life's unexpected events, you can plan for them by choosing benefits that help protect what's important to you.

ACCIDENT

Administered by Aetna

The Accident plan provides cash payments directly to you to help cover out-of-pocket costs, such as deductibles or coinsurance. The full schedule of benefits payable for accidental injuries include initial/follow-up treatment, ambulance trips, medical imaging, surgeries, concussion, dislocations and fractures, hospital stays, AD&D, and health screening benefits. It is important to note this benefit is for off the job accidents only. Some benefits are payable once per covered accident, while others are once per plan year. See Benefit Summary on page 29 for detailed information and schedule of benefits and exclusions.

CRITICAL ILLNESS

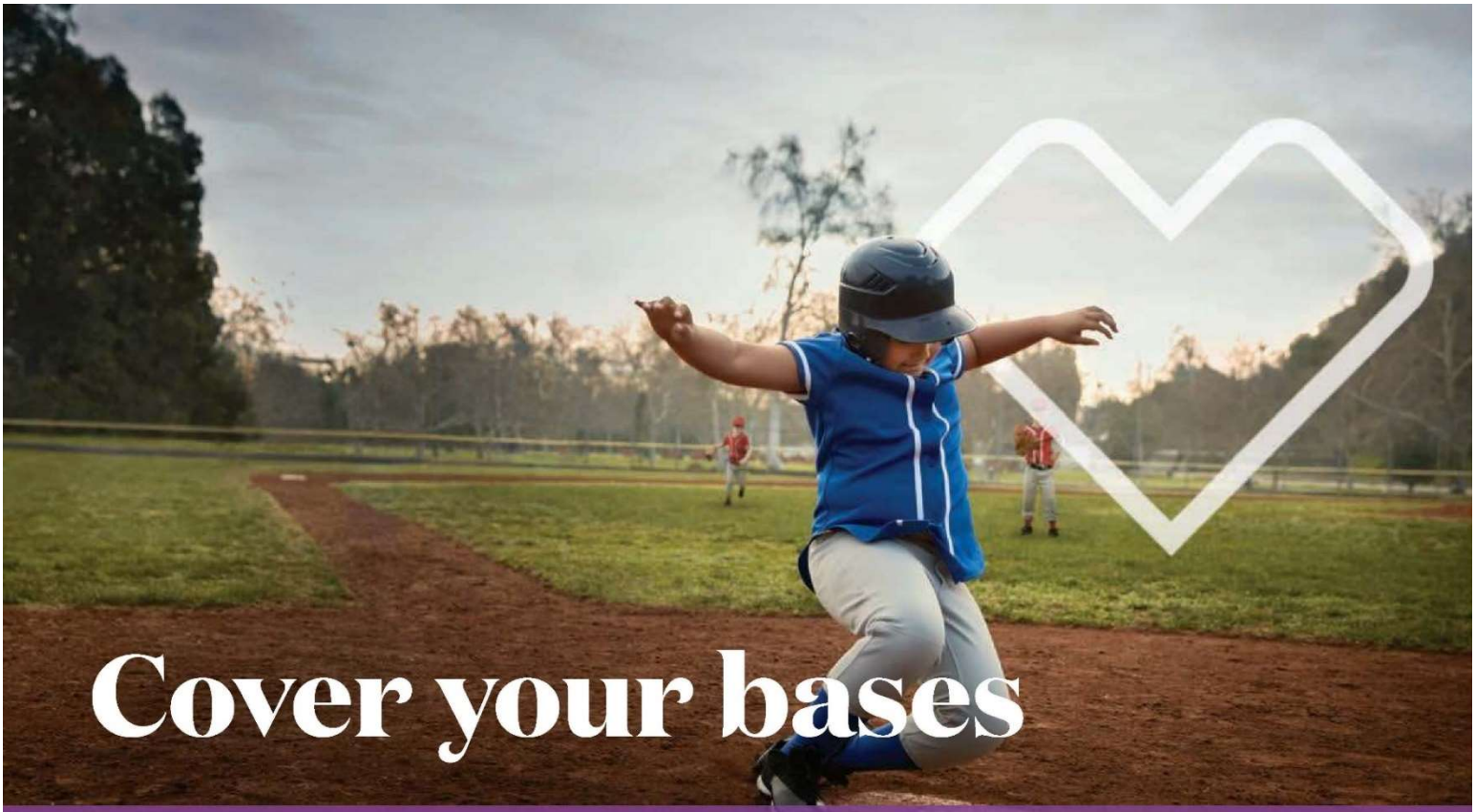
Administered by Aetna

Critical illness insurance provides a lump-sum payment for an insured person diagnosed with any of the following critical illnesses while insurance is in effect for the insured person, after any applicable waiting period and subject to any pre-existing condition limitation: Cancer, Heart Attack, Stroke, Organ Transplant, Kidney Failure, and more. See Benefit Summary on page 30 for detailed information and schedule of benefits and exclusions.

HOSPITAL INDEMNITY

Administered by Aetna

Hospital indemnity coverage eases the financial impact of an employee's hospitalization by providing a lump sum payment to help cover the costs associated with a hospital stay. Hospital indemnity coverage can be used to supplement medical insurance to help handle additional out-of-pocket costs that add up after a hospital stay. This can include copayments, coinsurance, deductibles, and incidental hospital expenses or other expenses such as transportation and lodging needs. See Benefit Summary on page 31 for detailed information and schedule of benefits and exclusions.



Cover your bases

Aetna® Accident Plan

Be prepared for the unexpected
Accidents are just that — accidents. You can't plan for them. But, you can protect yourself financially as much as possible.

An Aetna Accident Plan can help
The Aetna Accident Plan pays benefits when you get treatment for an accidental injury. The plan pays for a long list of covered minor and more serious injuries. You can use the benefits to help pay out-of-pocket medical costs or personal expenses.

How is this different from a major medical plan?
Medical plans help pay providers for services and treatment. But, they don't cover the unexpected costs that might come with an accidental injury.

The Aetna Accident Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

How can you use the cash benefits?
It's completely up to you. You can use the money any way you want. It can help you pay your:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or anything else you choose.

Easy to use
Online tools make it easy to manage your plan on our app or member portal. You can file a claim in about 90 seconds or less if you or a family member experience a covered injury or treatment. And, benefits get paid directly to you by check or direct deposit.

The Aetna Accident Plan is underwritten by Aetna Life Insurance Company (Aetna).

Aetna.com
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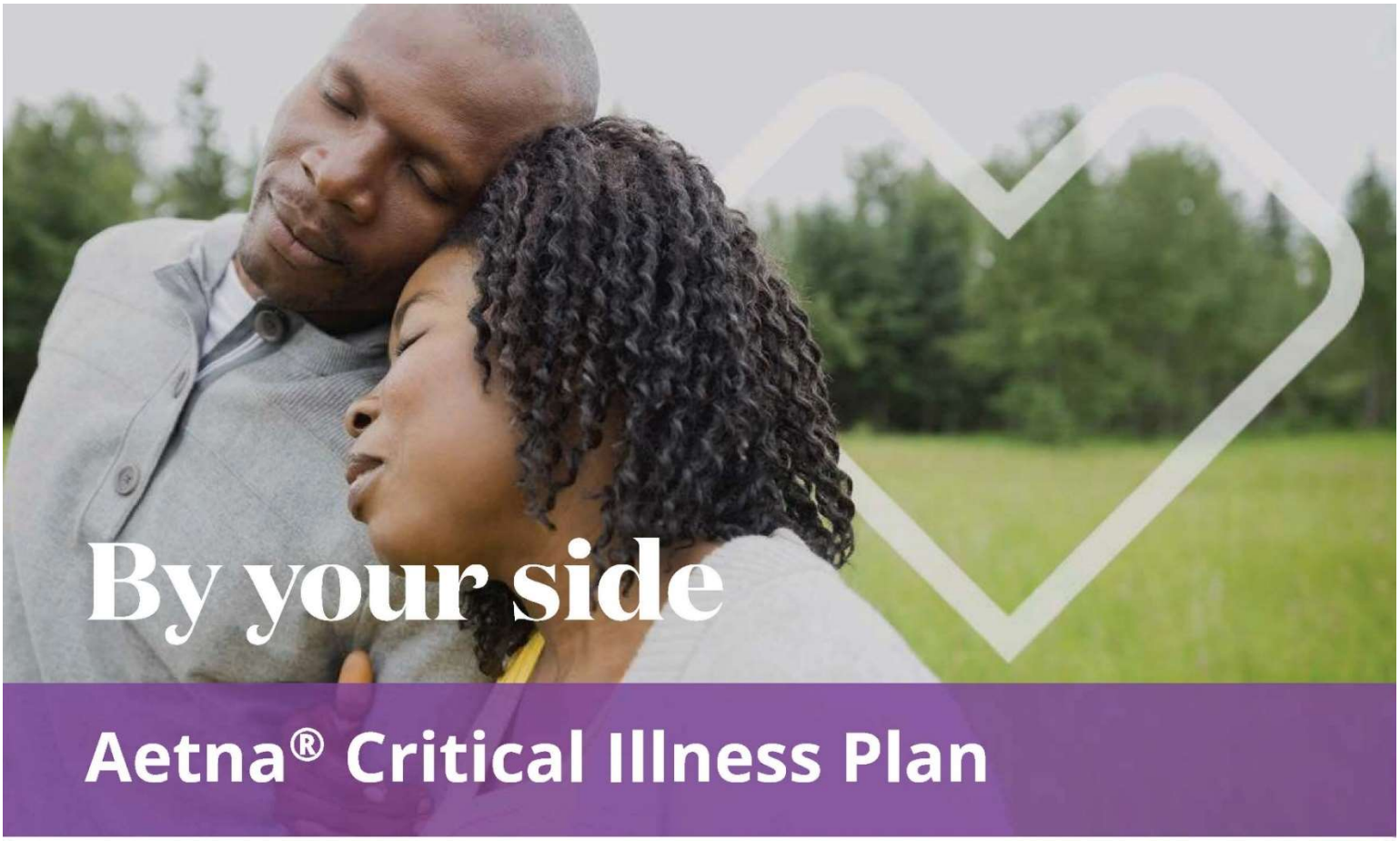


Aetna® Critical Illness Plan

Be prepared for what happens next
Critical illness coverage can keep you focused on your health when it matters most. These plans can help ease some financial worries during a difficult time.

An Aetna Critical Illness Plan can help
The Aetna Critical Illness Plan pays you lump-sum cash benefits when a doctor diagnoses you with a covered serious illness or condition, like heart attack, stroke, cancer and more.* You can use the money to help pay out-of-pocket medical costs or personal expenses.

How is this different from a major medical plan?
Medical plans help pay providers for services and treatment. But, they don't cover the unexpected costs that can come with a serious illness.

The Aetna Critical Illness Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

How can you use the cash benefits?
It's completely up to you. You can use the money any way you want, like:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or for anything else you choose.

Easy to use
You can file a claim in about 90 seconds or less if you or a family member experience a covered diagnosis or condition. And, benefits get paid directly to you by check or direct deposit.

*Refer to your plan documents to see all covered illnesses under the plan.

The Aetna Critical Illness Plan is underwritten by Aetna Life Insurance Company (Aetna).

Aetna.com
57.03.502.1 (02/21)

aetna

Aetna® Hospital Indemnity Plan

Be prepared for what lies ahead
Maybe you're expecting to have a hospital stay — or maybe not. Either way, you can plan ahead to give yourself an extra financial cushion.

The Aetna Hospital Indemnity Plan can help
The plan pays you a lump-sum cash benefit for a covered hospital admission and daily stays—even when you deliver a baby. You can use the money to help pay out-of-pocket medical costs or personal expenses. The choice is yours.

How is this different from a major medical plan?
Medical plans help pay providers for services and treatment. But, they don't cover the unexpected costs that might come with a stay in the hospital.

The Aetna Hospital Indemnity Plan pays benefits directly to **you,** giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

How can you use the cash benefits?
It's completely up to you. You can use the money any way you want. It can help pay:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or for anything else you choose.

Easy to use
Online tools make it easy to manage your plan on our app or member portal. You can file a claim in about 90 seconds or less if you or a family member experience a covered hospital stay. And, benefits get paid directly to you by check or direct deposit.

The Aetna Hospital Indemnity Plan is underwritten by Aetna Life Insurance Company (Aetna).

Aetna.com
57.03.503.1 (02/21)

aetna®

Supplemental health benefits, right at your fingertips.

With the new My Aetna Supplemental app and portal, managing your benefits is a breeze. Whether you're on your laptop or your mobile device, you can take charge of your supplemental coverage.

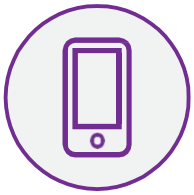
See how much easier it can be to manage your health benefits.

Either online or via the app, you can:

View coverage and benefits.

Submit and track claims.

Sign up for direct deposit of claims.



Submit documents — just take a picture with your phone and upload.

Access Aetna discount programs.

View and download other materials or forms from the document library.

Ready to discover the My Aetna Supplemental app and portal?

Ways to sign on:

- **Download the My Aetna Supplemental app** GET IT ON Google Play Download on the App Store
- **Log on to MyAetnaSupplemental.com** — the Aetna Supplemental Health member portal

Policies are insured by Aetna Life Insurance Company (Aetna). For more information about Aetna plans, go to Aetna.com.

MyAetnaSupplemental.com

aetna™

57.03.487.1 (10/19)

Aetna Simplified Claims Experience™

Aetna Accident, Critical Illness and Hospital Indemnity Plans

Filing claims for supplemental health benefits couldn't be easier

Get cash benefits fast

You can get cash benefits when you or a covered family member experience an accident, diagnosis of a serious illness or hospital stay.

It's easy to submit claims on the app or member portal

Here's how it works:

Download the **My Aetna Supplemental** app to your smart device. You can also **scan the QR code** to visit **Myaetnasupplemental.com.**

Register on the site if you haven't already. (You'll need your Aetna supplemental health Member ID or social security number.) Since you're a Meritain medical member, you can also access the member portal through **Aetna.com**.

1. Click on "Report New Claim."
2. Follow the steps and answer the questions.
3. Review your claim for accuracy and submit.

You or your covered family member have a covered event.

You submit a supplemental health claim on the app or member portal.

Our system matches the supplemental health claim to your Meritain medical claim to get information to help process your claim.*

We send your benefit to you by check or direct deposit.

*If you're not a Meritain medical member, you'll need to upload your medical documentation. Accepted documents include an itemized bill, or Uniform Medical Billing Form 2004 (UB04).

Get cash benefits for taking care of your health

The Aetna Accident Plan pays a **$50** cash benefit, and the Aetna Critical Illness and Hospital Indemnity Plans include an annual **$50** benefit for covered preventive health screening tests. This benefit is available once per covered member per year, per plan. Follow the same steps to file a claim and reap the cash rewards.

Other ways to file claims

You can also print and mail claims forms to Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or Fax to **1-859-455-8650**. Claims forms are available for download from the bottom of the screen when you access the member portal or call Aetna Member Services.

Have questions? Need help?

View your benefits summary on our secure member website, available 24/7. Or you can call Aetna Member Services Monday through Friday, 8 AM. to 6 PM at **1-800-607-3366 (TTY: 711).**

57.36.330.1 (2/21)

Protecting What Matters Most

Employee Benefit Plans

Identity theft can have serious repercussions. It can hurt your credit score, taint your medical records and drain your college funds and retirement accounts — everything you've worked so hard to build.

IdentityForce, a TransUnion® brand, has been helping people protect their identity and credit for over 40 years, and our Certified Resolution Specialists work diligently to keep you and your family safe.

Easy to Enroll

1. Enroll along with other voluntary benefits through your employer.
2. Receive Welcome email. If you do not receive the email, please check your spam folder.
3. Click on link in your Welcome email to complete registration and access your Identity Protection Dashboard.

Questions?

Call Member Services at

1-877-694-3367

PRICING

	UltraSecure ID	UltraSecure Premium
Individual plan | monthly	Employer Paid	$5.00
Family plan | monthly	$7.50	$12.00

PLAN FEATURES

	UltraSecure ID	UltraSecure Premium
MONITOR		
Advanced Fraud Monitoring		●
Change of Address Monitoring	●	●
Court Record Monitoring		●
Fraud Alert Reminders		●
Dark Web Monitoring	●	●
Compromised Credentials Monitoring	●	●
Account Takeover Monitoring	●	●
Dark Web Data Analysis	●	●
Short Term Loan Monitoring		●
Sex Offender Monitoring		●
Social Media Monitoring	●	●
ALERT		
Bank and Credit Card Activity Alerts		●
Investment Account Alerts		●
Identity Threat Alerts	●	●
Junk Mail Opt-Out	●	●
Smart SSN Tracker	●	●
CONTROL		
Medical ID Fraud Protection	●	●
Mobile App	●	●
Mobile Attack Control	●	●
Secure My Network (VPN)	●	●
Online PC Protection Tools		●
Identity Vault & Secure Storage	●	●
Password Manager	●	●
Two-factor Authentication	●	●
Lost Wallet Assistance	●	●
RECOVER		
Identity Restoration Specialist	●	●
Restoration for Pre-Existing Identity Theft	●	●
Fully Managed Family Restoration	●	●
Deceased Family Member Fraud Remediation*	●	●
Identity Theft Insurance ($1 Million)	●	●
Stolen Funds Replacement	●	●
Investment Accounts		●
CREDIT		
Credit Freeze & Credit Report Assistance	●	●
Credit Report Monitoring (Daily)		3 Credit Bureaus
Credit Report & Credit Score		Quarterly
Credit Score Simulator		●
Credit Score Tracker		Monthly

* Deceased Household Member Fraud Remediation available for adults or eligible dependents enrolled in an active IdentityForce Family Plan at the time of their death

ABOUT IDENTITYFORCE

IdentityForce, a TransUnion brand, offers proven identity, privacy and credit security solutions. We combine advanced detection technology, real-time alerts, 24/7 support and identity recovery with over 40 years of experience to get the job done. We are trusted by millions of people, global 1000 organizations and the U.S. government to protect what matters most.

Get the MySontiq app:

Download on the App Store | GET IT ON Google Play

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or Human Resources Department at Benefits@mohave.gov or 928-753-0736.

BENEFIT	VENDOR	PHONE	WEBSITE OR EMAIL
Medical Claims Administrator	Meritain	866.300.8449	www.meritain.com
Medical Review	American Health Group	800.847.7605	info@amhealthgroup.com
Medical Network - Arizona	Blue Cross Blue Shield of Arizona	877.635.2912	www.azblue.com/CHSNetwork
Medical Network – 49 Other States	Aetna	800.343.3140	www.aetna.com/docfind/custom/mymeritain
Telemedicine	Teladoc	800.835.2362	www.Teladoc.com
Prescription	Navitus	480.798.6268	www.navitus.com
Dental	Ameritas	800.487.5553	www.ameritas.com
Vision	VSP	800.877.7195	www.vsp.com
Vision	EyeMed	866.939.3633	www.eyemed.com
Health Savings Account	HSA Bank	800.357.6246	www.hsa.com
Flexible Spending Account	Meritain	800.566.9305	www.account.meritain.com
Life and AD&D	Ochs, Inc./Securian	800.392.7295	www.ochsinc.com
Employee Assistance Program	Curalinc	888.881.5462	www.suppotlinc.com
Voluntary Benefits	Aetna	800.607.3366	www.MyAetnaSupplemental.com
Identity Theft	Transunion	877.694.3367	securelis.identityforce.com
State Retirement Systems	AZ State Retirement System	1.800.621.3778	www.azasrs.gov
State Retirement Systems	AZ Public Safety Personnel Retirement System	1.602.255.5575	www.psprs.com

LEGAL NOTICES

Patient Protections Disclosure

The Mohave County Employe Benefit Trust Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.azblue.com.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Meritain 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 in our network 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 BCBSAZ at www.azblue.com.

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the The Mohave County Employee Benefit Trust Medical Plan .

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Your employer is committed to the privacy of your health information. The administrators of the Mohave County Employee Benefit Trust (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting your local Human Resources department.

Premium Assisstance 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.

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 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 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 July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

HIPAA SPECIAL Enrollment Rights

Mohave County Employee Benefit Trust Medical Plan **Notice of Your HIPAA Special Enrollment Rights**
Our records show that you are eligible to participate in the Mohave County Employee Benefit Trust Medical Plan . To actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction.

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 the 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).

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children’s Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan’s special enrollment provisions, contact your local Human Resources department.

Important Warning
If you decline enrollment for yourself or for an eligible dependent, you must complete a form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children’s health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan’s annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan.

Additional Privacy For Reproductive Healthcare

Federal law prohibits us from using or disclosing your information when it is being sought to investigate or impose liability on you, health care providers, or others who seek, obtain, provide or facilitate lawful reproductive health care, or to identify persons for such activities. This prohibition applies where we, or others acting on our behalf, have reasonably determined that: (1) The reproductive health care is lawful under the law of the state in which it was provided under the circumstances in which it was provided, for example, if a resident of one state traveled to another state to receive reproductive health care, such as an abortion, that is lawful in the state where such health care is provided; or (2) The reproductive health care is protected, required, or authorized by Federal law, including the U.S. Constitution, regardless of the state in which such health care is provided, for example, if the use of the reproductive health care, such as contraception, is protected by the Constitution; or (3) The reproductive health care was not provided by us, but we presume it was lawful.

However, if we receive a request for your information, and we have actual knowledge that the reproductive health care was not lawful under the circumstances under which it was provided to you, this presumption does not apply, for example, if you tell us you received reproductive health care from an unlicensed person, and we know that the specific reproductive health care must be provided by a licensed health care provider.

When we receive a request for your information potentially related to reproductive health care, we must obtain a signed attestation from the requester that the use or disclosure is not for a prohibited purpose when the request relates to health oversight activities, judicial and administrative proceedings, law enforcement purposes, and disclosures to coroners and medical examiners. For example, if we receive a lawful subpoena for medical records that include information related to reproductive health care, we must obtain a signed attestation from the requester that states the request is not for a prohibited purpose.

Notice of Creditable Coverage

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 Mohave County Employee Benefit Trust Medical Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:
1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Mohave County Employee Benefit Trust Medical Plan has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Mohave County Employee Benefit Trust Medical Plan coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Mohave County Employee Benefit Trust Medical Plan coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Mohave County Employee Benefit Trust and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable 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 that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Mohave County Employee Benefit Trust changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage 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).

Date: July 1, 2025
Name of Entity/Sender: Mohave County Employee Benefit Trust
Contact—Position/Office: Plan Trust Administrator
Office Address: 700 W. Beale Street
Kingman, Arizona 86401
Phone Number: 928.753.0736

COBRA GENERAL NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of
- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Mohave County Employee Benefit Trust
700 W. Beale Street
Kingman, Arizona 86401
928.753.0736

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up

Disclaimer
The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Summary does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

The information in this Benefits Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefits information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to HIPAA.

Remember, no action is required if you are not modifying your present benefit elections.
Exception: A yearly enrollment and contribution election *is required* for participants in the Flexible Spending Account.

Please contact your local Human Resources department for questions.

July 1, 2025 – June 30, 2026

Mohave County