YCT
Yavapai Combined Trust

2022

ANNUAL BENEFITS ENROLLMENT GUIDE

JULY 1, 2022 - JUNE 30, 2023

CITY OF PRESCOTT

TOWN OF CHINO VALLEY, ARIZONA

YAVAPAI COUNTY ARIZONA 1865

Yavapai COLLEGE

Yavapai Combined Trust (YCT) offers a comprehensive benefits program to help you and your family protect your health and financial security. Your YCT benefits are a valuable part of your compensation. We encourage you to learn how your plans work so you can maximize your benefits to meet your unique needs. This Benefits Enrollment Guide is designed to provide an overview of the benefit options that are available to you and your eligible dependents through the Yavapai Combined Trust. Read through this Guide to become familiar with the YCT benefit plans.

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

City of Prescott - "Click on the benefits tab at the top of the employee portal"

Town of Chino Valley - Go to https://chinoaz.hrintouch.com

Yavapai College - Go to "My Benefits"

Yavapai County - Go to: https://yavapaicounty.hrintouch.com

YCT is comprised of four entities: the City of Prescott, the Town of Chino Valley, Yavapai College, and Yavapai County. Our benefits plan is self-insured, with claims paid by an independent claims administrator. The Trustees meet once each quarter to review and vote on any action items. The Trust has appointed a committee, called the HR Advisory Group, which meets regularly to discuss problems, solutions, and make recommendations to the Trustees at their quarterly meeting.

YCT
Yavapai Combined Trust

Introducing Your YCT Benefits Plan

Things to Remember as You Use This Enrollment Guide

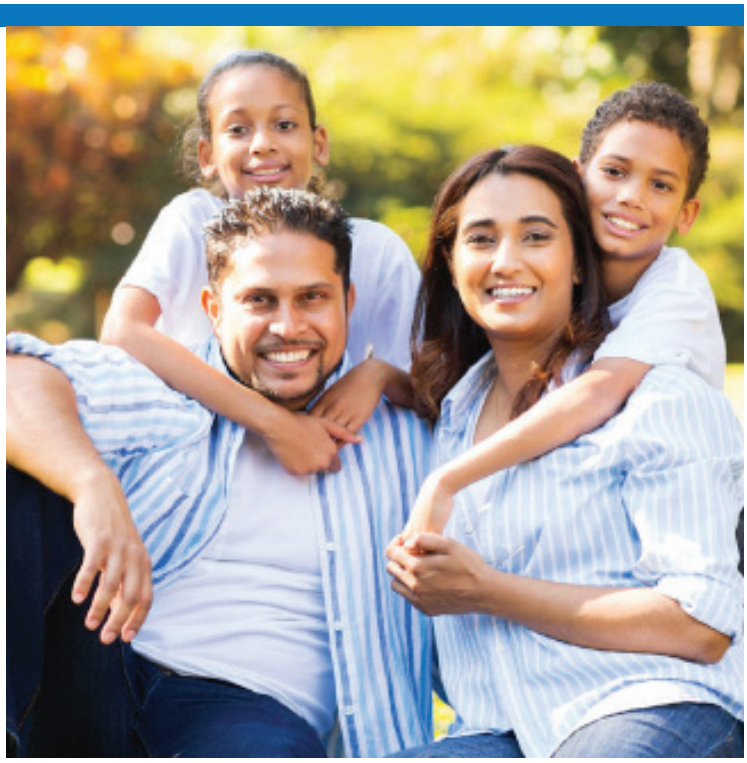
It's important that you understand the benefit plans offered to you by YCT. This is your opportunity to select the coverage appropriate for you and your eligible dependents. During Open Enrollment you can make changes to your benefits for the coming plan year. When enrolling, you may want to consider your needs for the coming year. You can change your plan, or add/drop coverage or dependents. Any changes you elect will be for the 12-month period that runs from July 1 through June 30. If you do not make any changes before your enrollment deadline, you will have to wait until the next Open Enrollment to be eligible for benefits unless you have a Special Enrollment Event or mid-year change in status, as defined on page 22 of this Guide.

During your initial benefits enrollment, newly benefits-eligible employees must enroll within 31 days of the date of hire or of becoming benefits-eligible.

You may take the following actions:

- Elect or waive Medical, Dental, and/or Vision coverage for yourself and qualified dependents.
- Elect Voluntary Life Insurance for yourself and qualified dependents.
- Elect or decline to participate in the Flexible Spending Account (FSA) plans.

Information at your fingertips!
Visit www.summit-inc.net for access to information on Summit Administration Services, Inc., the prescription drug program, FSAs, precertification, and more.



It's Important to Understand Your Benefits

Your HR Department and the Plan's Claims Administrators stand ready to answer your questions about your coverage and the options available to you and your family.

It is very important that you carefully review the 2022/2023 YCT Plan Document and understand your responsibility in the decisions you make regarding in-network versus out-of-network care.

Out-of-network care, such as an out-of-state facility or a non-network provider, will most likely result in a higher cost to you. Even if your in-network physician refers you to an out-of-network provider, claims will be reimbursed at out-of-network rates that could result in balance billing to you. **In-network providers offer your greatest value.**

It's important to check to see if a provider is in or out-of-network for your benefits. For Medical you can go online to www.summit-inc.net. For Dental visit Delta Dental at www.deltadentalaz.com/find.

Additionally, if you recieve care that is determined to be medically unnecessary, it will not be covered by the Plan. Remember your health care is ultimately your responsibilty, and we want you to get the care you need at the lowest cost to you.

YCT
Yavapai Combined Trust

Enrolling in the YCT Benefits Plan

How to Enroll

1. Read this Guide carefully for current information regarding your benefits.
2. Review your YCT Benefits Plan options to see which ones meet the needs for you and your family.
3. Careful planning is the key to getting the most from your benefits. By using the **Benefitfocus** Decision Making Tool, you can compare your medical plan options based on your personal medical claim history, then you can calculate your annual and monthly out-of-pocket cost for each plan. You will need to go to the **Benefitfocus** enrollment portal online to review your YCT benefits elections for details on your employee and employer's contributions.
4. You will need the Social Security number and date of birth for all dependents you enroll in the Plan.
5. Consider enrolling in a Health Savings Account (HSA) or Flexible Spending Account (FSA). You will need to enroll each year to participate. See pages 8 and 18 for more information.

The YCT Benefits Plan

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

The YCT Benefits Plan offers:

- Medical (PPO 350 Plan, PPO 600 Plan, and HDHP 2800 Plan with a Health Savings Account (HSA))
- Dental (Comprehensive and Basic)
- Vision
- Flexible Spending Accounts (FSAs) for health care and dependent care

We recommend that you go online during Open Enrollment to review your benefits, confirm your enrollment and make any changes, or your benefits will carry over from the previous plan year for the 2022-2023 plan year unless you have a Special Enrollment Event or mid-year change in status. If you want to contribute to a Health Savings Account or a Flexible Spending Account, you must enroll each year.

6. Consider supplementing your employer-provided life insurance with voluntary life. You can elect additional coverage for you, your spouse, and your dependent children. See page 17 for more information.
7. Be sure to review and update the beneficiary information on the YCT **Benefitfocus** enrollment portal even if you're not electing additional voluntary coverage.
8. During your initial benefits enrollment period, you must enroll within 31 days of your date of hire or of becoming benefits-eligible.
9. You must complete your enrollment online by the enrollment deadline, or you will have to wait until the next Open Enrollment, unless you have a Special Enrollment Event or mid-year change in status, as described on page 22.
10. Watch your mailbox for your Member ID/ Prescription Drug Cards within 14 days of the date you enroll for coverage as a New Hire or if you make benefit changes during Open Enrollment.

YCT Yavapai Combined Trust

What Happens if You Do Not Enroll?

Open Enrollment is the one time each year when you can make a change to your benefit elections. You must complete your enrollment online by the enrollment deadline, or you will have to wait until the next Open Enrollment, unless you have a Special Enrollment Event or mid-year change in status, as described on page 22. **You will also need to elect an HSA or FSA contribution each year if you wish to participate in a Health Savings Account or Flexible Spending Account.**

As a newly benefits-eligible employee, you must make your initial enrollment selections within 31 days of your date of eligibility. **If you fail to enroll within the 31-day enrollment period, you waive your right to enroll in these plans until the next Open Enrollment or until you have a Special Enrollment Event or mid-year change in status (see page 22 for more information).**

When Coverage Begins

The plan year is July 1 to June 30 each year. The benefits you elect now will go into effect on July 1, 2022, or if you are a new benefits-eligible employee, your coverage will become effective the first day of the month after you have been employed full time for 30 days.

Changing Your Coverage During the Year

Due to federal regulations, once you enroll in the YCT Benefits Plan, you will not be able to add or change coverage for yourself or your dependents until the next Open Enrollment period, unless you have a Special Enrollment Event under HIPAA or mid-year change in status as defined by the IRS. See page 22 for details about allowable changes to your elections.

Q&A

Q: Can I pick one medical plan for myself and another for my dependents?

A: No. You and your eligible dependents must all be enrolled in the same medical plan.

Q: Can I enroll in a medical plan for myself, and elect family coverage for the dental and vision plans or vice versa?

A: Yes. This is the beauty of the YCT Benefits Plan. You select the coverage that fits your needs.

YCT
Yavapai Combined Trust

Enrolling for Benefits

Flexible Spending Accounts

If you want to participate in a Flexible Spending Account (FSA), you must enroll each year. To participate in an FSA for the 2022-2023 plan year, you must indicate your contributions for the 12-month period when you enroll (see page 18 for more information).

Paying for Your Benefits

Each year, your employer contributes a certain amount to apply toward the cost of benefits. You can use these contributions to help pay for medical, dental, or vision coverage for you and your dependents. If the total cost of your benefit elections is more than your employer's contributions, you will have to make additional contributions via payroll deductions each pay period.

The Pretax Advantage

Your benefit premiums are deducted on a pretax basis, saving you federal, state, and Social Security taxes by reducing your taxable income. By having the pretax option, you cannot change coverage during the year, unless you have a Special Enrollment Event or mid-year change in status as per IRS guidelines, which restricts the type of changes you can make to your coverage during a plan year. See page 22 for details regarding mid-year changes to your elections.

YCT Yavapai Combined Trust

How the YCT Benefits Plan Works

Who's Eligible?

You are eligible if you are an employee of a participating employer of the YCT and are:

- Regularly scheduled to work full time as defined by your employer's personnel policy; or
- An elected member of a Governing Body, while in office (in accordance with a participating employer's eligibility policy).

If you elect medical coverage for yourself, your eligible dependents are also eligible for coverage on the latter of: (1) the day you become eligible for coverage, (2) the day they become an eligible dependent either by birth, adoption, or placement for adoption, or (3) the first of the month following the day they become an eligible dependent by marriage. You must complete your enrollment online within 31 days of your dependent becoming eligible for coverage or at Open Enrollment.

Eligible dependents include your:

- Lawful spouse; and
- Dependent child(ren), as defined in the YCT Plan Document.

NOTE: If you and your spouse both work for an employer participating in the YCT, you may each be covered as employees. You may also decide that instead of each employee electing coverage as an employee, one of you may elect coverage as the employee and the other as the dependent spouse. Also, dependent children may be covered by one spouse, not by both. See your YCT Plan Document for the definitions of "spouse" and "dependent children."

Your benefit elections can only be changed during Open Enrollment — unless you have a Special Enrollment Event or mid-year change in status — so plan your elections carefully. Make sure to complete Benefits Elections online before the deadline. If you want to contribute to a Health Savings Account or a Flexible Spending Account, you must enroll each year.

Dependent Children:

- Medical, Dental, and Vison plan benefits can be continued for a child up to the end of the month in which the child turns age 26.
- Dependent children who lose coverage under the YCT Plan due to no longer meeting the age eligibility criteria for a dependent child will become Qualified Beneficiaries entitled to elect COBRA continuation of coverage. Refer to the COBRA coverage reminder on page 22 for more information.

Questions about eligibility should be directed to your HR Department.

Member ID/Prescription Drug Cards

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

Employees who do not have medical coverage but have dental and/or vision will recieve ID cards. The Dental ID card will be from Delta Dental and the Vision ID card will be from Summit.

The Medical Plan

Your benefit plan offers you a choice of three medical plan options. Understanding the differences between the medical plan options can help you decide which plan is best for you and your dependents. For more detailed information, refer to your YCT Plan Document.

Medical Coverage Options

You may waive coverage or choose from the following options:

- PPO 350 Plan
- PPO 600 Plan
- HDHP 2800 Plan

Coverage Levels

Under the medical plan, you may elect coverage for:

- Employee
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

Use the Decision Making Tool available in Benefitfocus to compare your out-of-pocket costs and premiums for each plan.

All of the YCT Medical Plans include the Preferred Provider Organization (PPO) network of providers which allow you to use any qualified provider you choose without a referral. To find an in-network provider, go online to **www.summit-inc.net**.

PPO 350 Plan

You must meet the annual deductible ($350/person; $700/family) including copays for some services, and then most in-network expenses are paid at 80%. You also have the option to visit out-of-network providers, but you may have to pay additional money out of your pocket if you use out-of-network providers. You will need to meet a separate out-of-network deductible for non-network providers and services, and then eligible expenses are covered at 60%.

PPO 600 Plan

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

HDHP 2800 Plan

The HDHP 2800 allows you the greatest control over your out-of-pocket health care expenses. Once you meet your annual deductible ($2,800/person; $5,600/family), most in-network expenses are covered at 100% for the remainder of the benefit year.

When you enroll in the HDHP 2800, you can also contribute to a Health Savings Account (HSA) which allows you to use pretax contributions to pay for eligible health care expenses. Any money in your HSA will automatically roll over to future plan years, even if you are no longer enrolled in the HDHP 2800. You can find more on this HDHP 2800 option on page 7.

Terms to Know

Deductible: The amount of eligible expenses you must pay each year before the Plan begins to pay benefits.

Copay: The amount you pay to the provider each time you receive specific services.

Coinsurance: The portion of eligible medical expenses for which you have financial responsibility in excess of the Plan's deductible. For example, the PPO 350 pays 80% in-network, and then you pay 20%; the PPO 600 Plan pays 60% in-network, and then you pay 40% (after you have met your deductible).

Preferred provider: A health care provider (including doctors, hospitals, labs, and urgent care facilities) that is a member of the Blue Cross Blue Shield of Arizona Preferred Provider Organization (BCBSAZ PPO) network and who has agreed to charge lower, pre-negotiated discount fees for eligible services. To find an in-network provider, go online to www.summit-inc.net.

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

YCT Yavapai Combined Trust

Annual Out-of-Pocket Limit

Under the PPO 350 Plan and PPO 600 Plan, the out-of-pocket limit is the most you pay in coinsurance toward covered expenses during the plan year. After reaching the out-of pocket limit, generally the Plan then pays 100% for eligible expenses.

For the HDHP 2800, the amount you pay to satisfy your plan year deductible is included in the out-of-pocket limit.

For all medical plan options, if you use an out-of-network provider, you may be responsible for the difference between the Plan's allowed amount and the provider's billed charges. These charges do not apply to your out-of-pocket limit. When you seek out-of-network care, be sure to discuss your possible share of the costs with your provider before you receive care.

All the medical plan options allow you to choose any qualified provider without a referral.

NOTE: The HDHP 2800 has embedded deductibles. When a health plan has embedded deductibles, it means that a single member of a family doesn't have to meet the full family deductible for after-deductible benefits to kick in. Instead, your after-deductible benefits will go into effect as soon as you have met the individual deductible, even if the coverage is through a family plan.

Any money in your HSA will automatically roll over to future plan years, even if you are no longer enrolled in the HDHP 2800. However, you are only able to contribute to your HSA when you are enrolled in an HDHP 2800.

How the HDHP 2800 Works

With the HDHP 2800 plan your benefits will be the greatest when you choose in-network providers. You must meet the annual deductible (which is a high deductible) before the Plan pays qualified expenses. Like the PPO 350 Plan, you also have the option to visit out-of-network providers. However, the HDHP 2800 pays only 50% of allowable expenses for an out-of-network provider, and you will be responsible for the remainder plus any additional costs over the allowed amount.

Special Features of the Plan

If an HDHP sounds right for your situation, there are a few significant differences between this plan and the traditional PPO plans that you should consider. You must first pay the $2,800 individual or $5,600 family in- or out-of-network deductible before the Plan starts paying benefits. You can use the money in your HSA to pay for qualified health care expenses. After your deductible is met, the Plan's coinsurance pays 100% for in-network services and 50% for out-of-network services. There are exceptions for certain preventive medications and medical services that are not subject to the deductible.

The Medical Plan (continued)

A Health Savings Account (HSA) Is Available Only When You Enroll in the HDHP 2800

When you elect coverage under the HDHP 2800 option, you will be able to establish an HSA. You will receive more information from HealthEquity (the HSA Administrator) on how to make HSA contributions and how you can access the money in your HSA to pay for eligible health care expenses. In many instances, paying for eligible expenses is as easy as using your HSA debit card. However, keep in mind that the amount available to you can never exceed the amount in your HSA at the time of withdrawal. **You must enroll each year to continue contributing to your account.**

Enrolling in a Health Savings Account

You will need to complete your enrollment online in order to establish your account. This account can help you pay for eligible health care expenses for you and your family. The account is managed by HealthEquity and acts like a checking account with a debit card. The funds are available to you once they are deposited into your account, and you can use your HSA debit card to make qualifying purchases. If there is not enough money in your account to cover an eligible expense, you can be reimbursed for the amount once the funds have been deposited.

- For 2022-2023, if you are an active employee, you may contribute up to $3,650 for individual coverage and $7,300 for family coverage on a pretax basis. If you are 55 or older, you can also make an additional $1,000 catch-up contribution. Anyone can contribute to your HSA; however, only your employee contributions will qualify for pretax savings. You can use your HSA debit card to pay for qualified expenses for you and any dependents that you claim on your tax return.

5 Reasons to Enroll in an HSA

1. Your employer may contribute funds to your account.
2. Easy-to-use online access to check your account balance, pay bills, or get reimbursements.
3. Live Member Services specialists available 24/7. Get the help you need with personalized assistance from a specialist anytime, day or night. You can rely on a live Member Services specialist when you need help setting up payment schedules with a provider or have questions about a claim.
4. Safe, tax-free growth for your money. Your cash deposits are FDIC insured. In addition, you'll be earning tax-free interest. Even if you don't use all of the money in your account, your account balance will continue to grow each year, and you won't have to pay taxes on any interest earned.
5. No use-it-or-lose-it restriction. The money in your account can be used in years when you have greater-than-expected health care expenses. Or, at retirement, you can use the money to help pay for retiree health expenses. For more information, call the HSA administrator, HealthEquity, at 866-346-5800, or visit www.healthequity.com.

YCT Yavapai Combined Trust

The Medical Plan (continued)

Eligible Health Care Expenses

An HSA can help you pay for certain health care expenses that are not otherwise covered by the Plan, including costs toward your annual deductible. In general, eligible health care expenses include any nonreimbursable medical, dental, or vision expense that can otherwise be deducted on your individual tax return if you itemize deductions. Eligible deductions are described in IRS Publication 502.

If you pay expenses through your HSA, you have already used pretax dollars, so you cannot deduct those expenses on your individual tax return. You are responsible for determining whether or not an expense is eligible to be paid from your account. If you use the money in your HSA for non-eligible expenses, that distribution will be taxed, generally with a 20% penalty.

Special Note: In order to open an HSA and make tax-free contributions to your account, you must be HSA-eligible. IRS guidelines define an HSA-eligible individual as a person who:

- is covered under an HDHP,
- has no other health coverage (except as permitted by the IRS),
- is not enrolled in Medicare, Medicaid, or TRICARE during the plan year, and
- cannot be claimed as a dependent on someone else's tax return.

Some examples of reimbursable medical care can include:

- copayments and coinsurance amounts;
- prescription drugs;
- vision services including exams, eye surgery, glasses, and contact lenses;
- dental treatments;
- smoking cessation programs;
- weight-loss programs (if prescribed by your physician for a specific disease);
- chiropractic care;
- hearing aids;
- additional amounts you pay when you do not use an in-network provider (for example, amounts over the Plan's allowed amount);
- long-term care; and
- Medicare premiums (including Part A, Part B, Part D, and Medicare managed care) or premiums for COBRA coverage.

To see a complete list of allowable expenses, visit the IRS website at www.irs.gov and review Publication 502. If you still have questions, contact a Member Services specialist by calling HealthEquity at 866-346-5800 anytime, day or night.

The Medical Plan
(continued)

TELADOC™

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

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

Teladoc Gives You Choice, Convenience, and Control

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

What Kind of Doctors Will I Be Talking With?

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

How to Reach Teladoc?

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

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

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

To schedule an appointment, log in to the Summit website at **www.summit-inc.net** to register and set up your account.

1. **Request a visit**
   Request a visit with a doctor 24 hours a day, 365 days a year, by web, phone, or mobile app.
2. **Speak with a doctor**
   Talk to a licensed health care professional, and take as much time as you need... there's no limit!
3. **Obtain a prescription if necessary**
   If medically necessary, a prescription will be sent to the pharmacy of your choice.

YCT Yavapai Combined Trust

The Medical Plan (continued)

If you are enrolled in the PPO 350 Plan or the PPO 600 Plan, there is no cost for using Teladoc. For those enrolled in the High Deductible Health Plan (HDHP 2800), using Teladoc is $55 per consult (subject to a mid-year adjustment), and the cost is applied to your out-of-pocket limit.

When to Use Teladoc?

Use Teladoc for medical advice and care when:

- Your primary care doctor isn't available.
- You're at home or don't want to take time off work to see a doctor.
- You are out of state or when geographical barriers exist.
- You need a prescription or refills.
  Note: There is no guarantee you will be prescribed medication.

Who Can Use Teladoc?

Anyone covered by the medical plan is eligible to use a Teladoc professional.

What Can I Use Teladoc For?

Teladoc doctors can help with the following common medical conditions:

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

Employee Assistance Program (EAP)

Life can pull you in many directions. Find your worklife balance with the Employee Assistance Program.

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

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

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

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

The EAP also provides free and unlimited use of JBG Personal Care services. You can talk to a professional consultant for help with legal, financial, and identity theft assistance. You'll also find resources for housing, education, child and elder care, as well as discounts on thousands of personal home and business goods, without a membership fee.

To get started, call 888-520-5400, or visit the JBG website at www.jorgensenbrooks.com and click on the JBG Clinical Care tab, where you will find information on services and how to schedule a face-to-face appointment with a therapist. Download the EAP/Assist Mobile App available on Google Play or the Apple App Store.

The Medical Plan
(continued)

Prescription Drug Coverage

All three medical plan options offer outpatient prescription drug benefits through the OptumRx network. Outpatient prescription drug coverage is automatic when you enroll in a medical plan. You will not be able to opt out of prescription drug benefits coverage.

To find an in-network pharmacy, or to review the current formulary, go online to **www.summit-inc.net.**

From the Summit website, you can access the OptumRx prescription drug member website, **www.OptumRx.com.** All prescriptions must be filled at a network pharmacy or through the OptumRx Home Delivery service.

The OptumRx Formulary is a list of covered medications that will allow you to maximize the value of your prescription benefit. You can make the most of your pharmacy benefit plan and control your prescription medication costs by using this formulary. Be sure to share it with your doctor to elect cost effective medications that are clinically appropriate to treat your condition or maintain your health.

The formulary is updated quarterly. Medications that no longer offer the best therapeutic value for the plan are deleted, and a letter is sent to any member affected by the change. To review the current formulary or get up-to-date information on your pharmacy benefit, go online to **www.summit-inc.net** and click Contacts and Links, or go to **www.OptumRx.com** and sign in. If you have not logged in to the OptumRx website before, click on the Register link to get started. Enter your name, date of birth, and an email address, and then create a password to open your personal account.

The OptumRx Mobile App provides on-the-go access to your personalized health information when you need it. Visit **Google Play** or **Apple App Store** to download the OptumRx Mobile App to:

- Show your doctor exactly what drugs you are taking and view your prescription claims history.
- Find network retail pharmacies by ZIP Code or GPS location.
- Create and update automated text message reminders about taking and ordering your medications.
- Check the status of your mail service orders.

OptumRx Mail Service Pharmacy is a convenient and less expensive service available for plan participants who require maintenance medications for ongoing health conditions or who are going to be in an area with no participating retail pharmacy for an extended period of time. For more information call **800-562-6223 (TTY: 800-735-2922)**.

Clinical Prior Authorization is needed for certain medications before they can be filled, even with a valid prescription. The authorization process may be initiated by you, your local pharmacy, or your physician by calling OptumRx at **800-711-4555, Option 1** (5 a.m.-7 p.m. PT, Monday–Friday, 6 a.m.-3 p.m. PT, Saturday).

Quantity Limits: Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions.

Step Therapy means that coverage of a requested medication is approved only if you have tried certain other medications first and they did not work, or if you have specific medical conditions which preclude you from trying the alternatives. Step therapy is managed automatically when you bring your prescription to the pharmacy to be filled. The pharmacist will be able to tell you when they process your prescription and whether or not it is covered by your prescription plan.

YCT
Yavapai Combined Trust

The Medical Plan
(continued)

OptumRx Specialty Pharmacy Program:
Certain medications used for treating chronic or complex health conditions are handled through the Specialty Pharmacy. This program assists you with monitoring your medication needs for certain conditions and by providing patient education. Specialty medications are limited to a 30-day supply and may be obtained only at the Specialty Pharmacy. Call BriovaRx, the OptumRx Specialty Pharmacy at **855-427-4682**, or fax to **877-342-4596**, or log on to **www.OptumRx.com** for further information.

Features of Your OptumRx Pharmacy Plan Online:
Members enrolled in the medical plan can view pharmacy information online by going to **www.summit-inc.net** and click Contacts and Links and clicking on Prescription Coverage. From there you can access the **www.OptumRx.com** website.

- **Copay and Drug Information** – Compare copays at specific pharmacies or the Mail Service Pharmacy service so you can save.
- **Search the Formulary** – Research medications to determine whether they are generic, preferred, or non-preferred drugs; this will determine which copay is required.
- **Download the Formulary** – Print a copy for you and your doctor.
- **Locate and Map a Nearby Pharmacy** – View pharmacies in your area by ZIP code, including 24-hour pharmacies.
- **Go Mobile** – Sign up for text reminders to take and refill your medications.
- **Order Online** – Order medical supplies and health and wellness products.
- **Mail Service Forms** – Register for mail order service.
- **Prescription History** – View your prescription history.
- **Refill Information** – View refill information; find out when your next refill can be ordered.
- **Drug Information** – Research information on uses of the drug, side effects, precautions, and interactions.
- **Product News** – View latest product news available, including drug recalls and industry advances.
- **Area In-Network Pharmacies** – These include, but are not limited to, Safeway, Fry's, Walmart, CVS, and Walgreens.

Q&A

Q: What pharmacies can I use?

A: You can find a participating pharmacy online. Visit **www.summit-inc.net** and click Contacts and Links. From there you can access **www.OptumRx.com.**

Q: Where can I find the OptumRx Formulary?

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

Q: How long does it take to get a prescription through the mail service pharmacy?

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

Prescription Drug Tiers

1st Tier – Generics contain the same active ingredient as their brand name equivalents and are manufactured to offer the same effectiveness and safety. Generics generally have the lowest copay. Some low-cost brands may be included.

2nd Tier – Medications in this tier have been selected by your pharmacy benefit plan (OptumRx) as preferred brand drugs. These drugs have higher copays than generics but are less costly than non-preferred medications on the 3rd tier.

3rd Tier – If your medication has a generic version or 2nd tier alternative available, these will be considered as non-preferred medications. Non-preferred medications have the highest copays and are not listed on the Preferred Medication List (also called a Formulary).

For the HDHP 2800 your pharmacy benefit plan includes Expanded Preventive Drug Medications. These medications help protect against or manage medical conditions.The drugs on your plan's preventive medications list do not have a deductible. This means you'll pay your copayment/coinsurance or nothing at all.

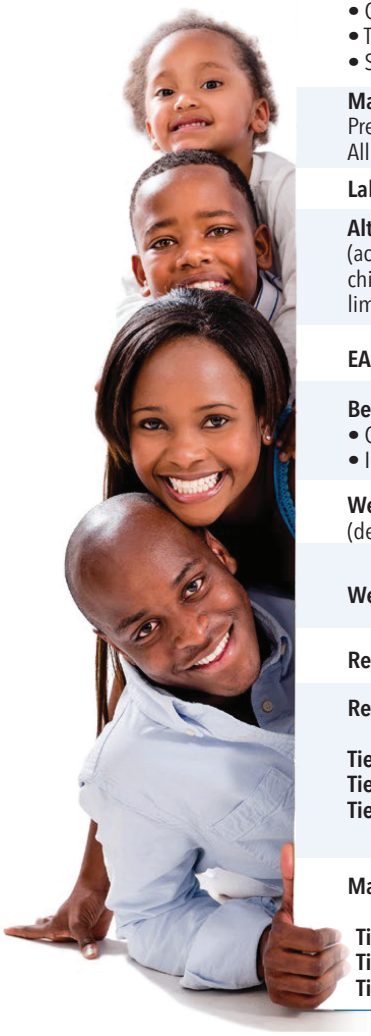
YCT
Yavapai Combined Trust

The Medical Plan (continued)

The table to the right shows a comparison of your medical plan and prescription drug benefits.

All admissions, procedures, or treatments over $1,000 require precertification.

Except in the case of emergency services performed in an emergency room, an out-of-network provider may bill you for the difference between actual charges and those considered allowable by the Plan.



Medical Plan Highlights and Comparison

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

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

YCT Yavapai Combined Trust

The Medical Plan (continued)

Medical Plan Highlights and Comparison (continued)

PPO 600 Plan		HDHP 2800 Plan	
In-Network[1]	**Out-of-Network**[3]	**In-Network**[1]	**Out-of-Network**[3]
$600/person; $1,200/family	$1,200/person; $2,400/family	$2,800/person; $5,600/family	
The deductible for in-network providers does not accumulate to meet the deductible for out-of-network providers and vice versa			
$6,600/person; $13,200/family In-network covered services plus in-network outpatient drugs accumulate to the in-network out-of-pocket limit	No out-of-pocket maximum	$2,800/person; $5,600/family	$10,000/person; $20,000/family
You pay a $150 copay/visit, then deductible, then the plan pays 60% and you pay 40%	You pay a $150 copay/visit, then deductible, then the plan pays 60% and you pay 40%	100% after deductible	
$60 copay/visit (deductible waived)	50%	100% after deductible	50% of the Allowed Charge after deductible
The plan pays 60% and you pay 40%	50%	100% after deductible	50% of the Allowed Charge after deductible
$30 copay/visit (deductible waived) No cost (deductible waived) $45 copay/visit (deductible waived)	50% Not covered 50%	100% after deductible	50% of the Allowed Charge after deductible
100% (deductible waived) $150 copay then you pay 20%	After you pay a $150 copay, the plan pays 50%	100% (deductible waived) Other services covered 100% after deductible	50% of the Allowed Charge after deductible
100% (deductible waived)	50%	100% after deductible	50% of the Allowed Charge after deductible
The plan pays 60% and you pay 40%	50%	100% after deductible	50% of the Allowed Charge after deductible
Up to 6 free visits per plan year with an EAP counselor per problem per person, by calling 888-520-5400		Up to 6 free visits per plan year with an EAP counselor per problem per person, by calling 888-520-5400	
The plan pays 60% and you pay 40% The plan pays 60% and you pay 40%	50% 50%	100% after deductible	50% of the Allowed Charge after deductible
100%	50%	100% (deductible waived)	50% of the Allowed Charge after deductible
Plan pays 100% (deductible waived). Routine wellness-related blood/lab tests covered at 100% in-network (deductible waived)		100% (deductible waived)	50% of the Allowed Charge after deductible
100% (deductible waived)	100% (deductible waived)	100% (deductible waived)	50% of the Allowed Charge after deductible
Up to a 30-day supply (deductible does not apply) $10 copay 20% of drug cost, $100 copay max 50% of drug cost, $20 copay min $150 copay max	**Up to a 90-day supply** (deductible does not apply) $30 copay 20% of drug cost, $300 copay max 50% of drug cost, $60 copay min $450 copay max	100% after deductible + Expanded Preventive Drug Medications	50% of the Allowed Charge after deductible
Up to a 90-day supply (deductible does not apply) $15 copay $40 copay $100 copay		100% after deductible + Expanded Preventive Drug Medications	50% of the Allowed Charge after deductible

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

YCT
Yavapai Combined Trust

Dental and Vision Plans

The Trust will now partner with Delta Dental and utilize the Delta Dental PPO & Premier Networks.

The Delta Dental Network has the largest network of dentists nationwide. The Delta Dental PPO Network provides the lowest out-of-pocket costs. That's because PPO Network dentist agree to accept lower reimbursements for services. The Delta Dental Premier Network provides a wider selection of dentists while keeping out-of-pocket costs economical. You may visit any network dentist, but you will save the most money by visiting a PPO dentist. To find an in-network dentist go to **deltadentalaz.com/find**.

Dental coverage is independent of medical coverage. You can elect to participate in a dental plan even if you waive medical coverage. Listed below is a comparison of your dental plan options. You can cover your child(ren) on both Dental plans up to age 26. For more detailed information, see your YCT Plan Document.

Dental Plan

You may choose to waive coverage or elect from the following dental options:

- Comprehensive Plan or
- Basic Plan

Coverage Levels

Under dental plan coverage, you may elect:

- Employee
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

The Comprehensive Plan & The Basic Plan both cover Preventive services at 100%, with no deductible. The differences between the plan options is the annual maximum, the percentage of coverage for Basic and Major Services and the cost of the benefits. The Basic Plan has in-network coverage only. Orthodontia is included for Adults & Children on the Comprehensive Plan option. The Comprehensive Plan has a maximum rollover feature which allows you and your dependents to rollover a portion of your unused annual Dental plan maximum when you get 2 preventive cleanings a year from one year to the next for future use.

Dental Plan Benefits Highlights and Comparison

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

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

Vision Plan

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

Coverage Levels

Under vision plan coverage, you may elect:

- Employee
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

The vision plan provides a $500 per-plan-year benefit per person to be used for any eligible expenses that may include vision exams, lenses and frames, prescription sunglasses, or contact lenses.

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

You can cover your child(ren) up to age 26. For more detailed information, see your YCT Plan Document.

YCT Yavapai Combined Trust

Additional Insurance

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

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

Basic Life Insurance

Basic Life Insurance coverage is automatically provided to all eligible employees on the first day of employment or on the date you become benefits-eligible with a participating employer. If you enroll your spouse or dependent child(ren) for coverage in one of the Trust's medical plan options, they automatically receive dependent basic life insurance coverage. The maximum benefit varies for each participating employer but is no lower than $10,000 for employees, $2,000 for your spouse, and $1,000 for each dependent child. For more information, contact your HR Department.

Voluntary Life Insurance

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

Coverage Options

Eligible employees may elect Voluntary Life Insurance coverage in increments of $10,000, to a maximum of $500,000.

For your spouse, you may elect Voluntary Life Insurance up to 100% of your total employee basic plus voluntary coverages combined in $5,000 increments, up to a maximum of $250,000.

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

- $2,000
- $5,000
- $10,000
- $15,000
- $20,000

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

During Open Enrollment, you can increase your employee coverage amount up to $10,000 without providing evidence of insurability. If you don't enroll when you're first eligible, you may be required to provide evidence of insurability.

Evidence of Insurability (EOI)

If you did not enroll for Voluntary Life Insurance coverage as a new employee or if you want to increase coverage, then you must provide evidence of insurability by completing the Evidence of Insurability Form and be approved for coverage. You are not required to provide evidence of insurability if:

- you are a new hire and eligible for this coverage for the first time, and
- you are electing the guarantee issue of $250,000 for employee, $50,000 for spouse coverage, or $20,000 per child.

Voluntary Life Insurance Rates

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

Short-Term Disability Insurance

Short-Term Disability insurance provides weekly income benefits if you cannot work due to a non-occupational, accidental injury or illness (including pregnancy). This coverage is provided automatically to plan participants by participating employers.

Flexible Spending Accounts (FSAs)

Flexible Spending Account Program – The Smart Way to Pay for the Things You Need

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

You Must Enroll in a Flexible Spending Account Each Year if You Want to Participate

- It is recommended you keep ALL receipts for all FSA-eligible expenses.
- If you lose your FSA Benefit Card, there is a $10 replacement cost.
- Once you use up your contributions for the plan year, do not throw the card away. It will continue to be good in future plan years, as long as you re-enroll and contribute to the FSA program.

Highlights of the Flexible Spending Account Program

- The plan year for the Flexible Spending Accounts is July 1, 2022, through June 30, 2023.
- You choose the annual amount to contribute, which is deducted from your check before taxes are taken out, lowering your taxable incomes.
- The maximum amount you can deposit each plan year to an FSA:

  Health Care – $2,850 ($2,500 for Yavapai County) to use to pay medical expenses not covered by your medical, dental, and vision plans such as copays, deductibles, and out-of- pocket expenses.

  Dependent Care – Up to $5,000 to use toward the costs of dependent day care services for eligible children and other qualifying dependents. The IRS sets limits under various circumstances. You may be eligible to claim the dependent care tax credit on your federal income tax return. Consult your tax advisor to determine which gives you the greater advantage.

- Pretax funds are deposited into your Health Care and/or Dependent Care account via payroll deduction. If you elect to contribute to the Health Care FSA, your total annual contribution is available to use at the time of election. However, if you contribute to the Dependent Care FSA, only the amount deposited each pay period is available to use.
- When you first enroll, you will receive an FSA Benefit Card in the mail.
- You can use your FSA Benefit Card to pay for qualified purchases at many merchants and service providers, or you can mail in a claim form for reimbursement.
- Replacement cards can be obtained by calling Summit Administration Services, Inc., and paying a $10 replacement cost.
- Unused amounts do not carry over to the next plan year.
- The Claims Administrator is Summit Administration Services, Inc. For more information, please contact Summit Administration Services, Inc., at 888-690-2020.

YCT Yavapai Combined Trust

Flexible Spending Accounts (FSAs) (continued)

Manage Your FSA Online

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

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

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

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

Flexible Spending Accounts Life Events/Mid-Year Changes

You cannot change your elections to your Health Care and/or Dependent Care Flexible Spending Accounts after enrollment unless you have a Special Enrollment Event. For more information, see page 22.

Plan Carefully!

It is important to plan carefully and set aside only as much money in your FSA as you intend to use each plan year. IRS regulations require that all money contributed to your FSAs must be used to pay for expenses incurred during that plan year only, otherwise your money is forfeited.

You can continue to file claims until September 30, 2023 for eligible expenses incurred during the plan year between July 1, 2022 and June 30, 2023. You can use the money in your account to pay eligible expenses incurred by any of your qualified dependents even if they are not covered under your health plan.

If you elect the HDHP 2800 with an HSA

If you are electing to enroll in the HDHP 2800 with an HSA, **you will not be able to make any contributions to your HSA** if you enroll in a general purpose Health FSA. However, if you have a **limited** purpose Health FSA, which covers eligible expenses for dental and vision care only, you will still be able to contribute to your HSA.

To find out more about contributing to a limited purpose Health Care FSA, contact your HR Department.

You can continue to file claims until September 30, 2023, for expenses incurred from July 1, 2022, through June 30, 2023.

Flexible Spending Accounts (FSAs) (continued)

Use Your Flexible Spending Account to Help Pay for Eligible Expenses Not Covered Under Your Plan

Health Care Expense Examples

Eligible expenses for reimbursement are defined by the IRS. In general, you can use the money in your FSA to pay for eligible health care expenses that are not covered by your insurance.

For a general purpose Health Care FSA, eligible health care expenses include your deductible and copays for prescription drugs or medical, dental, or vision care.

You can also use your account to pay for expenses that exceed your plan benefit limits or to pay for care if you are not enrolled in the dental or vision plan.

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

For a limited purpose Health Care FSA, eligible health care expenses include dental and vision care.

Dependent Care Expense Examples

Eligible expenses under this type of account are expenses incurred for dependent care that is necessary so that you can be gainfully employed.

This dependent care can be for any member of your household who is a dependent and meets the following general government stipulated definitions of eligible dependents:

- A qualifying child up to age 13 (older if physically or mentally incapable of self-care) and has the same principal residence as the employee for more than half the year.
- A qualifying relative of any age who has a gross income of less than a certain amount. Day care services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes. You will need to provide the tax ID number of the day care provider on submitted claims.

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

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

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

Wellness Benefits

Nothing is more important than your health.

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

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

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

YCT Yavapai Combined Trust

Wellness Benefits
(continued)

Marquee Health

YCT is committed to helping employees achieve their best health. Marquee Health provides YCT Employees & Spouses enrolled in one of YCT's medical plans with personalized health coaching, education and referral services, and other wellness resources to help you get healthy and stay healthy.

Unlimited health coaching is at the core of every Marquee Health Program. Health coaching through Marquee is based on a holistic, mind-body approach that views good health as a balance of physical, financial, and emotional well-being. Our Health Educators will work with you to develop a personal action plan which includes: discussing your health and wellness interests; providing you with educational materials and guidance to support your wellness plan; and offering support and resources to help you achieve your goals.

In addition to telephonic health coaching, a wide array of resources are available to you on the Marquee Health website. Through this site, you will have access to health improvement modules, wellness tips, food trackers, personal health assessments, interactive wellness video, recipes, and health encyclopedias. In addition, through the 'My Communications Center' portion of the portal, you can connect with us by scheduling a video or web chat consultation with a Marquee Health Educator.

Web: mymarqueehealth.com
New users will select 'Register for a new account', enter the Code yct then use your company email to create a profile.

Email: coaching@marqueehealth.com
Phone: 800-882-2109

Tria Health

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

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

- Diabetes
- Heart disease
- High Cholesterol
- High Blood Pressure
- Mental Health
- Asthma/COPD
- Osteoporosis
- Migranes
- Pain
- Specialty Medications

Not only can your Tria Health pharmacist help you save money by identifying savings opportunities within your current medication regimen, active participants with diabetes will also have free access to a wireless blood glucose meter, testing strips, and mobile app designed to help better manage your diabetes.

Schedule your first appointment, visit www.triahealth.com/enroll or call 1.888.799.8742 to speak with a Tria Health member advocate.

Important Plan Information

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

Mid-Year Changes To Your Health Care Benefit Elections
IMPORTANT: After the Open Enrollment period is completed, (or, if you are a new hire, after your initial enrollment election period is over), generally you will not be allowed to change your benefit elections or add/delete dependents until next year's Open Enrollment, unless you have a Special Enrollment Event or a Mid-year Permitted Election Change Event as outlined below:

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

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

Medicaid/CHIP Event: You and your eligible dependents may also enroll in this plan if you (or your dependents):

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

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

Mid-Year Permitted Election Change Event:
Because the Trust pretaxes benefits we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year. The following events may allow certain changes in benefits mid-year, if permitted by the IRS:

- Change in legal marital status (e.g. marriage, divorce/legal separation).
- Change in number or status of dependents (e.g. birth, adoption, dependent's death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a Qualified Medical Child Support Order (QMCSO).
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify the plan in writing within 31 days of the mid-year election change event by contacting your HR Department. The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved mid-year election change event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Important Reminder to Provide the Plan With the Taxpayer Identification Number (TIN) or Social Security Number (SSN) of Each Enrollee in a Health Plan
Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

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

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

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact your HR Department.

COBRA Coverage Reminder
In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

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

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

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

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

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs. That notice must be sent to your HR Department via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA contact Summit Administration Services, Inc.

YCT
Yavapai Combined Trust

Important Plan Information (continued)

Availability Of Summary Health Information:
The Summary Of Benefits and Coverage (SBC) Documents(s)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer friendly **Summary of Benefits and Coverage (SBC)** as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the SBC summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including: what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan has to follow about how the SBCs look, how many pages long the SBC should be, the font size, the colors used when printing the SBC and even which words are to be bold and underlined.

A Uniform Glossary that defines many of the terms used in the SBC is available at **https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf.** To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for your medical plan options, go to **Benefitfocus** or contact your HR Department.

Caution: If You Decline Medical Plan Coverage Offered Through YCT
The medical plan options offered by YCT are considered to be minimum essential coverage (MEC) and meets the government's minimum value standard. Additionally, the cost of medical plan coverage is intended to be affordable to employees, based on employee wages.

If you are in a benefits-eligible position and choose not to be covered by one of YCT's medical plan options, you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace **(www.healthcare.gov),** typically at the Marketplace annual enrollment is in the fall each year.

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

If you choose to not be covered by a YCT medical plan at this enrollment time, your next opportunity to enroll for YCT's medical plan coverage is at the next annual Open Enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of YCT's plan year.

You Must Be Qualified To Contribute To A Health Savings Account
The eligibility requirements to open and contribute to a Health Savings Account (HSA) are mandated by the Internal Revenue Service (IRS), not by your employer. Individuals who enroll in a Health Savings Account (HSA) but are later determined to be ineligible for that account, are subject to financial penalties from the IRS. It is an individual's responsibility to ensure that they meet the eligibility requirements to open an HSA account and to have contributions made to that HSA account, as outlined below:

- To be eligible to open an HSA and have contributions made to the HSA during the year, an individual must be covered by an HSA qualified health plan (an HDHP) and must not be covered by other health insurance that is not an HSA-qualified plan. Certain types of insurance are not considered "health insurance" and will not jeopardize an individual's eligibility for an HSA, including automobile, dental, vision, disability, and long-term care insurance.

- **IMPORTANT:** Individuals enrolled in Medicare aren't eligible to open an HSA or have contributions made to the HSA during the year. If you think you could become eligible for Medicare in the next 12 months you should reconsider whether enrolling in the medical plan that is paired with a health savings account is a wise choice.

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

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

Medicare Notice Of Creditable Coverage Reminder

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, the prescription drug coverage that you elect from YCT under the PPO 350 Plan, the PPO 600 Plan, or the HDHP 2800 Plan is creditable with (as valuable as) Medicare's prescription drug coverage.

For more information on whether the prescription drug coverage under the medical plan options offered by YCT are or are not creditable,review the Plan's Medicare Part D Notice of Creditable Coverage available online.

Important Plan Information (continued)

The Claims Administrator Summit Administration Services, Inc., is responsible for processing all the claims for medical, vision and short-term disability; providing verification of benefits and eligibility, as well as administering the FSA Plan and COBRA. Contact Summit Administration Services, Inc. by calling 1-888-690-2020 or access their website at www.summit-inc.net.

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

The Precertification Administrator is American Health Group, Inc. (AHG). AHG helps to assure all treatments are medically necessary and appropriate. All admissions and treatments and/or services that are greater than $1,000 require precertification. For more information, call 800-847-7605.

Designation of a Primary Care Provider (PCP)
The medical plans offered by YCT do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of an out-of-network provider.

Direct Access To OB/GYN Providers:
You do not need prior authorization (pre-approval) from YCT or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, go online to www.summit-inc.net.

Privacy Notice Reminder
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. You can get another copy of this Notice from your HR Benefits Team.

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

IMPORTANT INFORMATION ABOUT THE YAVAPAI COMBINED TRUST WELLNESS PROGRAM

Our Yavapai Combined Trust (YCT) Wellness Program is voluntary and is designed to promote health or prevent disease. The term Wellness Program includes both:

a. ways that we help individuals identify and reduce health risk factors, like elevated blood pressure or excess weight, along with

b. ways to help individuals with chronic conditions, like diabetes, take better care of their condition, for example by working with a coach to encourage you to take the medication the doctor prescribes for your chronic condition.

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

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

Reasonable Alternative Standard: If you think you might be unable to meet a standard for a certain reward under our Wellness Program, you might qualify for an opportunity to earn the same reward by a different means. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the Wellness program, or if it is medically inadvisable for you to attempt to achieve the standards of the Wellness Program, then a reasonable alternative standard will be made available upon request. Contact Summit Administration Services for information on the Wellness Program and for information on reasonable alternative standards and accommodations. We will work with you and, if you wish, your doctor, to find an alternative Wellness Program standard with the same reward that is right for you in light of your health status. If your personal doctor states that the alternative is not medically appropriate, a more accommodating alternative will be provided.

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

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

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.

YCT Yavapai Combined Trust

Important Plan Information (continued)

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 (As of January 31, 2022) you may be eligible for assistance paying your employer health plan premiums. (AL, AK, AR, CA, CO, FL, GA, IN, IA, KS, KY, LA, ME, MA, MI, MN, MT, NE, NV, NH, NJ, NY, NC, ND, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, WV, WI, WY). To see if any other states have added a premium assistance or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
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 1/31/2023)

NOTICE REGARDING THE YCT WELLNESS PROGRAM

The Yavapai Combined Trust Wellness Program is a voluntary wellness program available to all benefits-eligible employees, their spouses and dependents and is designed to promote health or prevent disease. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

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

However, those who choose to participate in the Wellness Program will receive a participation prize and be eligible for a grand prize. Although you are not required to complete the HRA or participate in the biometric screening, only those who do so will receive prizes.

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

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Wellness Program and YCT may use aggregate information it collects to design a program based on identified health risks in the workplace, YCT Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

In addition, all medical information obtained through the YCT Wellness Program will be maintained separately from your personnel records and no information you provide as part of the YCT Wellness Program will be used in making any employment decision. Appropriate precautions will be taken by YCT to avoid any data breach, and in the event a data breach occurs involving information you provided in connection with the YCT Wellness Program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the YCT Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation related to the YCT Wellness Program, please contact Summit Administration Services at **800-690-2020**.

If You Need More Information About…	Contact…
• Medical and Vision Claims • Eligibility • COBRA Administration • HIPAA Certificate of Coverage • Short-Term Disability (for employees of participating employers of the Trust) • FSA Administration	Summit Administration Services, Inc. P.O. Box 25160 Scottsdale, AZ 85255-0102 1-888-690-2020 or 480-505-0400 M – TH 8:00 a.m. – 5:00 p.m. F 8:00 a.m. – 4:30 p.m. Fax: 480-505-0407 **www.summit-inc.net**
• Utilization Management Program • Precertification of Medical/Surgical Services • Medical Review Services • Case Management Services	American Health Group, Inc. (AHG) 2152 S. Vineyard Ave., #103, Mesa AZ 85210 602-265-3800 or 800-847-7605 **www.amhealthgroup.com**
• Medical Preferred Provider Network (PPO Preferred In-Network Providers) • Network Behavioral Health Providers	Blue Cross Blue Shield of Arizona (BCBSAZ) **www.azblue.com** Blue Preferred PPO Network
• Dental Network (PPO & Premier In-Network Providers) • Dental Claims • Dental Eligibility	Delta Dental **www.deltadentalaz.com/member** 602-938-3131 or 800-352-6132 PPO & Premier In-Network
• Health Savings Account Administration	HealthEquity Member Services: 866-346-5800 **www.healthequity.com**
• Employee Assistance Program (EAP)	Jorgensen Brooks Group Clinical Care Services: 888-520-5400 **www.jorgensenbrooks.com**
• Retail/Mail Order Prescription Drug Program • Retail Network Pharmacies • Prescription Drug Information and Formulary • Prior Authorization of Drugs • Specialty Managed Drugs	OptumRx Customer Service: 800-562-6223 Clinical Prior Authorization: 800-711-4555 Option 1 OptumRx Specialty Pharmacy: 866-218-5445 **Home Delivery Mail Service:** Customer Service: 800-562-6223 (TTY: 800-735-2922) **www.summit-inc.net** or **www.OptumRx.com**
• Yavapai Combined Trust (YCT)	**Plan Administrator:** Wendy Ross Phone: 928-771-3252 Fax: 928-771-3419
• Yavapai College	Human Resources Department 1100 E. Sheldon Prescott, AZ 86301 Phone: 928-776-2217 Fax: 928-776-2202 **AskHR@yc.edu**
• City of Prescott	Human Resources 201 S. Cortez Prescott, AZ 86303 Phone: 928-777-1279 Fax: 928-777-1213
• Yavapai County	Human Resources 1015 Fair Street, Rm. 338 Prescott, AZ 86305 Phone: 928-771-3252 Fax: 928-771-3419
• Town of Chino Valley	Human Resources Department 202 N. State Route 89 Chino Valley, AZ 86323 Phone: 928-636-2646 Fax: 928-636-9129

YCT Yavapai Combined Trust

Notes:

Notes:

YCT
Yavapai Combined Trust

Notes:

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