NAPEBT
Serving Those Who Serve the Public

Important Plan Information for NAPEBT Participants

Updated March 2015

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.

CAUTION: IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH NAPEBT

If you are in a benefits-eligible position and choose not to be covered by one of the medical plan options offered through NAPEBT and your employer, remember that 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 in the fall each year.

Americans without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Health Insurance Marketplace for detailed information on individual shared responsibility payment penalty.

If you choose to not be covered by a medical plan sponsored by NAPEBT and your employer at this enrollment time, your next opportunity to enroll for 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 your employer's plan year.

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.

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 Human Resources Department.

AFFORDABLE CARE ACT: NOTICE OF PATIENT PROTECTION: PRIMARY CARE PHYSICIAN (PCP) AND OB-GYN PROVIDERS

It is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires/allows designation of a primary care physician; or (2) obtain obstetrical or gynecological care with prior authorization.

NAPEBT and Blue Cross Blue Shield of Arizona (BCBSAZ) generally allow the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the BCBSAZ network and who

is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from NAPEBT or BCBSAZ or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB-GYN) care from a health care professional in the BCBSAZ network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, visit http://www.azblue.com or call the BCBSAZ member services at (800) 423-6484.

MID-YEAR CHANGES TO YOUR MEDICAL PLAN ELECTIONS

IMPORTANT: Once you make a benefit election, generally you **will not** be allowed to change your benefit election or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment event or a Mid-year Change in Status.

SPECIAL ENROLLMENT EVENT:

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

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

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

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

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

MID-YEAR CHANGE IN STATUS EVENT:

Because your employer pre-taxes benefits, NAPEBT and your employer 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 Internal Revenue Service (IRS):

- Change in legal marital status (e.g. marriage, divorce/legal separation, death).
- Change in number or status of dependents (e.g. birth, adoption, death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a 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 change in status event by contacting your Human Resources Department. The Plan will determine if your change request is permitted and if so, will notify you of the date the change will be effective prospectively, generally the first day of the month following the date of the mid-year change event. Note that for timely notification of the addition of a newborn or adopted child, coverage is effective back to the date of birth, adoption, or placement for adoption.

HIPAA PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans like NAPEBT 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 Human Resources Department or on the Plan's website at www.napebt.com.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL REMINDER

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

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

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact the medical plan claims administrator or your Human Resources Department.

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the NAPEBT Medical Plan options available to you is or is not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the plan options offered by NAPEBT are or are not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage (at the back of this notice) or available from your Human Resources Department or on the NAPEBT website at www.napebt.com.

COBRA COVERAGE

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 qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

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

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

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

In order to have the 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 should be sent to your Human Resources 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 your Human Resources Department.**

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(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 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 Summary of Benefits and Coverage (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 had to follow about how the SBCs look, how many pages the SBC should be (maximum 4-pages, 2-sided), the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

The SBC for each medical plan option may be attached to this packet of information. To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, go to www.napebt.com or contact your Human Resources department.

NAPEBT OFFERS A HIGH DEDUCTIBLE HEALTH PLAN WITH A HEALTH SAVINGS ACCOUNT. YOU MUST BE QUALIFIED TO CONTRIBUTE TO A HEALTH SAVINGS ACCOUNT. HELPFUL REMINDERS BELOW:

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 (a 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 a 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.
- Individuals can't open an HSA, and have contributions made to the HSA during the year, if a spouse's health insurance, health flexible spending account (FSA) or health reimbursement arrangement (HRA) can pay for any of an individual's medical expenses before the HSA-qualified plan deductible is met. This means that a standard general purpose health care flexible spending account (FSA) may make you ineligible to open an HSA and have contributions made to the HSA during the year.
- If an individual received any health benefits from the Veterans Administration or one of their facilities, including prescription drugs, in the three months prior, they are not eligible to open an HSA and have contributions made to the HSA during the year.

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.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Blue Cross Blue Shield of Arizona at (800) 423-6484 to precertify the extended stay. If you have questions about this Notice, contact your Human Resource office.

NOTICE TO ENROLLEES IN THE NAPEBT MEDICAL PLAN (A SELF-FUNDED NONFEDERAL GOVERNMENTAL GROUP HEALTH PLAN)

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy.

NAPEBT has elected to exempt the Northern Arizona Public Employees Benefit Trust Medical Plan from the following requirements:

- **Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.**

The exemption from these Federal requirements will be effective for the 2015 NAPEBT plan year beginning on July 1, 2015 through June 30, 2016. The election may be renewed for subsequent plan years.

For the 2015 plan year NAPEBT is going to continue to provide the same mental health and substance abuse and Employee Assistance Program (EAP) benefits we offered in the 2014 plan year. This means that you will still have access to inpatient admissions to a maximum of 30 days per year, and unlimited outpatient mental health and substance abuse services received through the Behavioral Services Administrator (BSA); but certain requirements of the Parity regulation will not have to be met by the NAPEBT Medical plan. Additionally, behavioral therapy for the treatment of Autism Spectrum Disorder is still available for members who have been diagnosed with Autism Spectrum Disorder.

NAPEBT reserves the right to amend the Northern Arizona Public Employees Benefit Trust Medical Plan during the plan year and you will be notified of any plan amendments.

If you have any questions regarding this exemption, please contact your Human Resources department.

IMPORTANT INFORMATION ABOUT THE WELLNESS PROGRAM

All employees participating in a NAPEBT-sponsored health plan have the opportunity to qualify for wellness program incentives at least once a year. Our NAPEBT Wellness Program is voluntary and is designed to promote health or prevent disease.

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) and the tobacco cessation incentive does not exceed 50% of the total cost of employee-only coverage.

If an employee has physical disabilities or a medical condition such that it is unreasonably difficult due to their medical condition to satisfy the standards of the wellness program, reasonable alternatives will be made available upon request. If the individual's personal physician states that the alternative is not medically appropriate, a more accommodating alternative will be provided. Contact your Human Resources office for information on the wellness program and the need for reasonable alternatives.

EMPLOYER EXCHANGE NOTICE

Contact your Human Resource department for another copy of the Employer Exchange Notice which is provided to new employees.

MEDICARE PART D NOTICE
Important Notice from Northern Arizona Public Employees Benefit Trust (NAPEBT) about Prescription Drug Coverage for People with Medicare

This notice is for people with Medicare.
Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with Northern Arizona Public Employees Benefit Trust (NAPEBT) and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage.

At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

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

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

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

Northern Arizona Public Employees Benefit Trust (NAPEBT) has determined that the prescription drug coverage is "creditable" under the following medical plan options (the Base Plan, the Buy-up Plan, and the High Deductible Health Plan).

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

Because the plan option(s) noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the Base Plan, the Buy-Up Plan, and the High Deductible Health Plan and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

YOUR RIGHT TO RECEIVE A NOTICE

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

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

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

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

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

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

WHAT ARE MY CHOICES?

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

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage with the Base Plan, the Buy-up Plan, and the High Deductible Health Plan, and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through Northern Arizona Public Employees Benefit Trust (NAPEBT). □ You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th - December 7th of each year). □ As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	You can select or keep your current medical and prescription drug coverage with the Base Plan, the Buy-up Plan, and the High Deductible Health Plan **and also enroll in a Medicare prescription drug plan.** If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that you will still be able to receive all your current health coverage and this Plan will coordinate its drug payments with Medicare, as follows: □ for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary. □ for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under the Base Plan, the Buy-up Plan, and the High Deductible Health Plan. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop your current medical and prescription drug coverage with NAPEBT at this Plan's Open Enrollment period. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: □ PDPs may have different premium amounts; □ PDPs cover different brand name drugs at different costs to you; □ PDPs may have different prescription drug deductibles and different drug copayments; □ PDPs may have different networks for retail pharmacies and mail order services.

IMPORTANT NOTE:

If you are enrolled in the High Deductible Health Plan (HDHP) with the Health Savings Account (HSA) you may not continue to make contributions to your HSA once you are enrolled in Medicare including being enrolled in a Medicare Part D drug plan.

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

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year

from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

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

For more information about this notice or your current prescription drug coverage contact your Human Resources or Benefits Department at:

Coconino County	679-7104
City of Flagstaff	213-2097
Flagstaff Housing Authority	526-0002
Coconino Community College	226-4350
Flagstaff Unified School District	527-6046
NAIPTA	679-8920
CCRASD#99	679-8072

As in all cases, Northern Arizona Public Employees Trust (NAPEBT) reserves the right to modify benefits at any time, in accordance with applicable law. This document is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

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