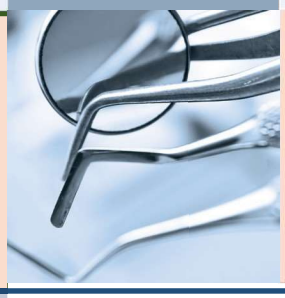
Employee Benefit Guide

Cochise Combined Trust



Cochise County

July 1, 2023 – June 30, 2024

TABLE OF CONTENTS

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 36 for the Notice of Creditable Coverage for more details.

Open Enrollment

April 1 – 30, 2023

Open enrollment is your opportunity to review your benefits and make changes to your coverage, add or remove a dependent from coverage. Open enrollment begins April 1 and ends April 30 each year. If you do not make changes to your enrollment your current elections will stay in-force for the 2023-24 plan year.

- Review Insurance Coverage and select Medical/Rx EPO, EPO Buy Up or HDHP, Dental, and Vision plans.
- Choose Tier - employee only, employee plus spouse, employee plus child or employee plus family.
- Elect Flexible Spending Account (FSA) or Health Savings Account (HSA)
- Elect Dependent Daycare Flexible Spending Account (DDC FSA)
- Enroll, change, or terminate Voluntary Benefits

The cost of healthcare continues to be a significant concern. To help control healthcare costs, we all need to take an active role in our healthcare options and choose a healthier lifestyle. Better choices include utilizing Teladoc and urgent care instead of the emergency room, when appropriate, choosing generic medications and participating in on-site preventive screenings and wellness programs. Making wise choices in how you spend healthcare dollars can make a difference in the future of all our healthcare costs.

Enrollment Dates and Deadlines

Employees who are:	Enrollment Deadline	Effective date of coverage	Documentation required
Currently Active	April 30, 2023	July 1, 2023	Marriage and/or birth certificate or other court document for newly added spouse and/or dependents
New hire or rehire	Must enroll within 31 days of hire	First of the month following date of hire	Marriage and/or birth certificate or other court document for added spouse and/or dependents
Making a status change from part- time to full-time or full-time to part-time	Must enroll within 31 days of status change	First of the month following status change	Marriage and/or birth certificate or other court document for added spouse and/or dependents
Having a qualifying event	Must enroll within 31 days of qualifying event	Day of the life event	Marriage and/or birth certificate or other court document for added spouse and/or dependents and proof of life event
Terminating employment	Benefits automatically end	Last day of the month in which employee terminates	N/A

About Your Benefits

At Cochise County, we are committed to providing a comprehensive and valuable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your benefits. If you have any questions, feel free to reach out to Human Resources at 520.432.9700 or HumanResources@cochise.az.gov.

Eligibility and Enrollment

You are considered benefit eligible if you are a regular status employee scheduled to work a minimum of 20 hours or more per week. If you enroll for benefits, you may also cover your:

- Legal spouse
- Children up to age 26
- Unmarried children of any age who are mentally or physically disabled

Your benefits begin on the first of the month following your hire date. Please refer to the Summary Plan Document (SPD) for each benefit to confirm whether you, your spouse and dependents are eligible.

Select Your Benefits Carefully

To get the most value from your benefits, carefully consider which options are right for you and your family. Because premiums for certain benefits are deducted on a pre-tax basis, IRS regulations may prohibit you from making enrollment changes until the end of the plan year, unless you experience a qualified election change. Pre-tax benefits include: medical, dental, and vision.

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during Annual Enrollment. Any pre-tax benefit elections made during open enrollment must remain in effect until the following Annual Enrollment period, unless you experience a qualifying event which may allow for an election change. Examples of qualified life events include:

- Marriage, legal separation, divorce, annulment, or death of a spouse
- Birth, adoption of a child, legal guardianship, or death of dependent child
- Change of an employee's or spouse's employment
- Change in a dependent's eligibility status
- Loss of eligibility for group health coverage, health insurance coverage, or Medicaid/CHIP
- Becoming eligible for a state premium assistance subsidy

If you believe you have a qualifying event please notify Human Resources immediately. You have 31 days from a qualified change in status to make changes. However, note that if you lose eligibility for Medicaid/CHIP, or become eligible for a state premium assistance subsidy, you have 60 days from that qualified change in status to make changes.

Keep in mind, the changes you make must be directly related to the event.

What's New for the 2023-24 Plan Year

EPO Changes

Change Specialty Pharmacy co-pay to 20% up to $150

Increase Primary Provider co-pay to $30

Increase Specialist and Teladoc co-pay to $40

Increase Out-of-pocket maximum to $9,100/$18,200

Change non-hospital Physical or Occupational Therapy to $10 co-pay

Enhance the Copay Max Rx Plus Program, adding certain Brand name medications to the eligible list. See Page 12 for additional information.

Buy Up EPO Changes

Change Specialty Pharmacy co-pay to 20% up to $150

Increase Primary Provider co-pay to $30

Increase Specialist and Teladoc co-pay to $40

Increase Out-of-pocket maximum to $5,500/$11,000

Change non-hospital Physical or Occupational Therapy to $10 co-pay

Enhance the Copay Max Rx Plus Program, adding certain Brand name medications to the eligible list. See Page 12 for additional information.

HDHP Changes

Increase Non-Network deductible to $7,500/$15,000

Life Insurance Changes – This Enrollment Period Only

Employees can elect $50,000 for the first time or can increase their current coverage by $50,000 not to exceed $300,000 during this ONE-TIME GUARANTEED ISSUE OPPORTUNITY. No Health questions or evidence of insurability required.

Medical Coverage

Terms to Know

- **Copay** - A set dollar amount you pay for a covered healthcare service for EPO and EPO Buy-Up plans, usually when you receive the service.
- **Deductible** - What you pay out of pocket for healthcare services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered healthcare services after you reach the deductible. You pay a percentage of the cost, and the medical plan pays the rest.
- **Out-of-pocket Maximum** – The maximum amount of copays, deductible and coinsurance you are responsible for in a plan year before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide healthcare services. In-network providers typically provide services at a lower negotiated rate. If you receive services from a provider that is **In-Network** it will cost you significantly less than going to a provider that is **Out-of-Network.**
- **Formulary Drug List:** A drug formulary is a list of generic and brand-name drugs that have been evaluated for safety and effectiveness, and that your insurance company considers "best choices."
- **Generic Drugs**: FDA-approved, and shown to be just as safe and effective as their more expensive brand-name counterparts.
- **Brand Name Drugs:** Carriers regularly review the latest prescription drugs on the market and maintains a list of brand name drugs that are clinically effective and not cost-restrictive.
- **Specialty Drugs:** Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using the carrier's mail-order pharmacy. You can register for mail-order pharmacy by logging on to **www.navitus.com**.

How the Plans Work

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

HDHP (High Deductible Health Plan): You pay the full negotiated cost for medical services and prescription drugs until you meet your annual deductible. Since the deductible and the annual maximum out-of-pocket are the same on this plan, if you meet the deductible, the plan will cover 100% of the in-network approved charges until the end of the plan year.

EPO and EPO Buy Up: These Plans have set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays and coinsurance until you reach your annual out-of-pocket maximum.

Telemedicine

Getting to the doctor when you're sick is never easy. That's why Teladoc offers telemedicine for non-emergency medical care. You can connect with a U.S. board-certified medical professional by phone or video chat. For further details , visit www.teladoc.com.

Medical and Prescription Coverage Highlights – EPO Plan

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Comprehensive healthcare also provides peace of mind.

	EPO Plan	EPO Plan
	IN-NETWORK	OUT OF NETWORK
Deductible (Individual/Family)	$500/$1,500	No Coverage
Coinsurance	20%	No Coverage
Out-of-Pocket Maximum (Individual/Family)	$9,100/$18,200	No Coverage
BASIC & PHYSICIAN CARE		
Preventive Care	$0	No Coverage
Primary Care Office Visit	$30 copay	No Coverage
Specialist Office Visit	$40 copay	No Coverage
Virtual Visits	$30 PCP $40 Specialist	No Coverage
Diagnostic Testing Lab/X-ray Under $500	$30	No Coverage
Advanced Imaging and diagnostic lab or x-ray over $500	Deductible + 20%	No Coverage
Non-Hospital owned OT and PT	$10 copay	No Coverage
SICK AND QUICK CARE		
Teladoc – General Health	First two visits $0 then $40	N/A
Urgent Care Facility	$35 copay	No Coverage
Emergency Room	$250 plus 20% coinsurance after deductible	$250 plus 20% coinsurance after deductible
HOSPITALIZATION		
Inpatient Hospital	Deductible + 20%	No Coverage
Outpatient Surgery over $500	Deductible + 20%	No Coverage
BEHAVIORAL HEALTH		
Outpatient Mental Health	$30 PCP $40 Specialist	No Coverage
Inpatient Mental Health and Substance Abuse	Deductible + 20%	No Coverage
PHARMACY	Preferred Pharmacy	Non-Preferred Pharmacy
Retail (up to 30 days)	Generics $10 copay Formulary Brand Name $30 copay Non-Formulary Brand Name $60 copay	Generics $15 copay Formulary Brand Name $35 copay Non-Formulary Brand Name $65 copay
Retail or Mail Order (90 days)	Generics $20 copay Formulary Brand Name $60 copay Non-Formulary Brand Name $120 copay	Generics $25 copay Formulary Brand Name $65 copay Non-Formulary Brand Name $125 copay
Specialty Drugs	20% up to $150	Not Covered
Non-network pharmacy reimbursements will be determined according to the Network price of the prescription.		

Certain procedures, treatments, services and products require precertification or prior authorization through AmeriBen or Navitus. Please contact AmeriBen at 800.388.3193 for medical and Navitus at 866.333.2757 for prescriptions.

Medical & Prescription Coverage Highlights – EPO Buy-up Plan

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Comprehensive healthcare also provides peace of mind.

	EPO Buy Up Plan	EPO Buy Up Plan
	IN-NETWORK	OUT OF NETWORK
Deductible (Individual/Family)	$250/$750	No Coverage
Coinsurance	20%	No Coverage
Out-of-Pocket Maximum (Individual/Family)	$5,500/$11,000	No Coverage
BASIC & PHYSICIAN CARE		
Preventive Care	$0	No Coverage
Primary Care Office Visit	$30 copay	No Coverage
Specialist Office Visit	$40 copay	No Coverage
Virtual Visits	$30 PCP $40 Specialist	No Coverage
Diagnostic Testing Lab/X-ray Under $500	$30	No Coverage
Advanced Imaging and diagnostic lab or x-ray over $500	Deductible + 20%	No Coverage
Non-Hospital Owned OT and PT	$10 copay	No Coverage
SICK AND QUICK CARE		
Teladoc – General Health	First two visits $0 then $40	N/A
Urgent Care Facility	$35 copay	No Coverage
Emergency Room	$250 plus 20% coinsurance after deductible	$250 plus 20% coinsurance after deductible
HOSPITALIZATION		
Inpatient Hospital	Deductible + 20%	No Coverage
Outpatient Surgery over $500	Deductible + 20%	No Coverage
BEHAVIORAL HEALTH		
Outpatient Mental Health	$30 PCP $40 Specialist	No Coverage
Inpatient Mental Health and Substance Abuse	Deductible + 20%	No Coverage
PHARMACY	Preferred Pharmacy	Non-Preferred Pharmacy
Retail (up to 30 days)	Generics $10 copay Formulary Brand Name $30 copay Non-Formulary Brand Name $60 copay	Generics $15 copay Formulary Brand Name $35 copay Non-Formulary Brand Name $65 copay
Retail or Mail Order (90 days)	Generics $20 copay Formulary Brand Name $60 copay Non-Formulary Brand Name $120 copay	Generics $25 copay Formulary Brand Name $65 copay Non-Formulary Brand Name $125 copay
Specialty Drugs	20% up to $150	Not Covered
Non-network pharmacy reimbursements will be determined according to the Network price of the prescription.		

Certain procedures, treatments, services and products require precertification or prior authorization through AmeriBen or Navitus. Please contact AmeriBen at 800.388.3193 for medical and Navitus at 866.333.2757 for prescriptions.

Medical and Prescription Coverage – HDHP

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Comprehensive healthcare also provides peace of mind.

	HDHP Plan	HDHP Plan
	IN-NETWORK	OUT OF NETWORK
Deductible (Individual/Family)	$3,000/$6,000	$7,500/$15,000
Coinsurance	0% after Deductible	50% after Deductible
Out-of-Pocket Maximum (Individual/Family)	$3,000/$6,000	$200,000/$400,000
BASIC & PHYSICIAN CARE		
Preventive Care	$0	Not Covered
Primary Care Office Visit	0% after Deductible	50% after Deductible
Specialist Office Visit	0% after Deductible	50% after Deductible
Virtual Visits	0% after Deductible	50% after Deductible
Independent Lab/X-Ray (non-hospital owned)	0% after Deductible	50% after Deductible
Independent Diag MRI / CT	0% after Deductible	50% after Deductible
SICK AND QUICK CARE		
Teladoc – General Health	0% after Deductible	N/A
Urgent Care Facility	0% after Deductible	50% after Deductible
Emergency Room	0% after Deductible	0% after Deductible
HOSPITALIZATION		
Inpatient Hospital	0% after Deductible	50% after Deductible
Outpatient Surgery	0% after Deductible	50% after Deductible
BEHAVIORAL HEALTH		
Outpatient Mental Health (30 visit Max)	0% after Deductible	50% after Deductible
Inpatient Mental Health and Substance Abuse (Limited to 2 inpatient confinements per lifetime and max of 30 days per plan year)	0% after Deductible	50% after Deductible
PHARMACY	Preferred and Non-Preferred Pharmacy	Non-Network Pharmacy
Retail (up to 30 days)	0% after Deductible	50% after Deductible
Mail Order (90 days)	0% after Deductible	50% after Deductible
Specialty Drugs	0% after Deductible	Not Covered

Certain procedures, treatments, services and products require precertification or prior authorization through AmeriBen or Navitus. Please contact AmeriBen at 800.388.3193 for medical and Navitus at 866.333.2757 for prescriptions.

Telemedicine

Administered by Teladoc

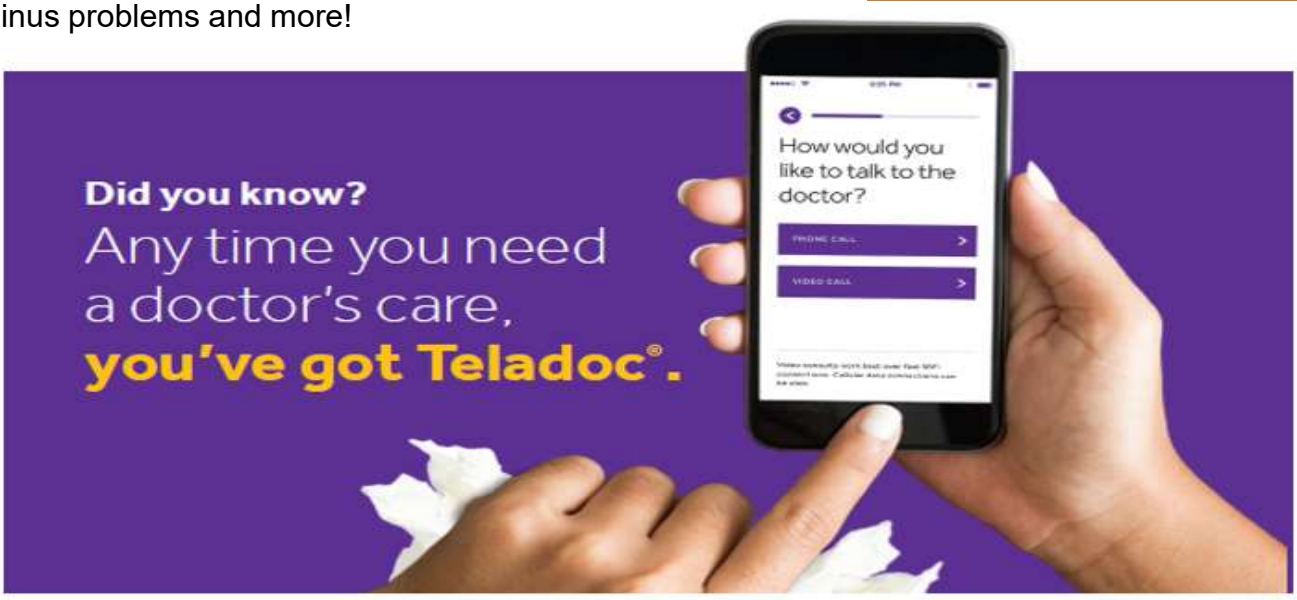
Avoid expensive emergency room visits by using Teladoc. The average cost of an E.R. visit is $1,912. You may be responsible for a copayment, deductible and coinsurance depending on which plan you are enrolled in so it may cost you between $250 to $1,912. Compare this to $55 for HDHP members or $40 for EPO members (first two visits per plan year are free).

Connect with an experienced board-certified physician to treat common issues like:

- ❖ Cold and Flu Symptoms
- ❖ Allergies
- ❖ Bronchitis
- ❖ Skin Problems
- ❖ Respiratory infections
- ❖ Sore Throat
- ❖ Sinus problems and more!

It's Easy!

Create an account and complete the medical history today. It will save you time when you are ready to see the Doctor.



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Cold & flu, allergies, rash and much more!

Licensed doctors
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Get a diagnosis
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Prescription Drug Information

The prescription drug program is administered by Navitus. You are automatically enrolled in the prescription drug plan when you enroll in the medical plan.

Formulary Facts

A formulary is a comprehensive list of preferred drugs chosen based on quality and efficacy by a committee of physicians and pharmacists. The drug formulary serves as a guide for the provider community by identifying drugs which are covered. It is updated regularly and includes both generic and brand name medications.

Checking your Formulary

You can find the Cochise Combined Trust (CCT) formulary on the Navitus member portal. You can browse by category of use or look up alphabetically. Also included is information about which drugs need prior authorization or have quantity limits. The coverage or tier for each drug product is noted but the dollar amount you pay for each medication is not listed on the site. See the Pharmacy Benefit Schedule on pages 7-9 for cost-sharing information.

Preventative Medications

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

Customer Service

You can find additional information about your prescription drug plan at **www.navitus.com**, or contact Navitus Customer Service at 866.333.2757. Both resources are available 24 hours a day, 7 days a week.

Mail Order

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

It is easy to enroll:

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

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

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

Reducing Drug Costs with Copay Assistance

Many high-cost specialty and HIV drugs have copay assistance programs. With these programs, manufacturers pay for part of the drug cost. This may help reduce what you pay. If you are using a drug that is eligible for copay assistance, you must enroll in the program.

Navitus is here to help you enroll to take advantage of these savings.

Getting Started is Easy!

1. A patient representative from your specialty pharmacy will reach out to you to help you enroll. If you already use copay assistance, your out-of-pocket cost will not change.
2. After enrolling, make sure your pharmacy has your copay assistance processing information.
3. Only the amount you have paid out-of-pocket will apply to your annual deductible and/or out-of-pocket maximum.

Frequently Asked Questions

How do I know if my drug has a copay assistance program?

Visit the drug manufacturer's website to see if they have a program for your medication. Many high-cost brand and specialty drugs are eligible for copay assistance. Most generic drugs are not eligible.

Will I have to reenroll in copay assistance?

Some copay assistance programs require reenrollment annually. Please contact the drug manufacturer or your specialty pharmacy provider to confirm your continued enrollment.

Where can I find out more information about copay assistance?

You can find additional details in your Summary Plan Description (SPD) document, which is typically provided in your benefit enrollment information.

What if I am not eligible for my drug's copay assistance program?

If you are not eligible, call Navitus Customer Care at 866.333.2757 to discuss your options. There may be other assistance programs available.

EPO and Buy-Up EPO Plans Only

NAVITUS HEALTH SOLUTIONS

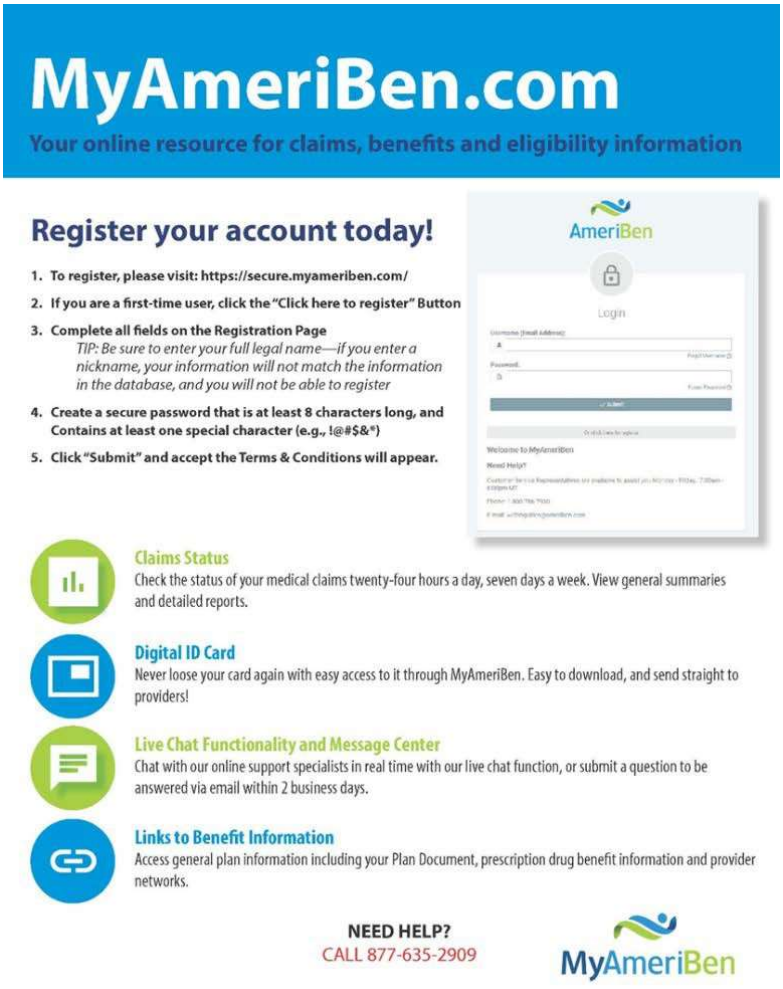
Medical Network

Access the Find A Doctor tool for lists of doctors, other healthcare professionals, hospitals, and facilities. Search for a provider in your plan's network by provider name, type of provider, or within a certain distance of your location. It's important to verify providers are in your plan's network before you see them. If you have a HDHP, providers who are not in your plan's network will cost you more. If you have an EPO plan, providers who are not in your plan's network will not be covered by your plan. When talking with a provider, always ask, "Do you take my BCBSAZ plan?" Most providers are in a BCBSAZ network – but not all providers are in every BCBSAZ plan's network. That is why it is important to ask if they take your plan. You can also call the number on the back of your member ID card to determine providers are in your network.

Log in to www.azblue.com/chsnetwork , choose Arizona PPO as your plan then click on "Find a Doctor."

Medical Claims Administration

After you visit the doctor, in-network providers send the claim to BCBSAZ for repricing. BCBSAZ discounts it based on the agreement they have with that provider. Once repriced, it is sent to AmeriBen for processing and payment. AmeriBen compares the billing codes to the Summary Plan Description to verify the charges are for covered services. If approved, it is processed for payment. The provider will receive a check, and the participant will receive an Explanation of Benefits (EOB) explaining how the claim was paid. If you receive a bill from your provider and do not receive and EOB from AmeriBen, you should call AmeriBen at 1.855.258.6455 to inquire if they have received the claim or you can contact your provider to verify they have your correct insurance billing information. Non-network providers send their claims directly to AmeriBen for processing or payment. If you have questions or would like assistance with understanding the plan, please call AmeriBen toll-free at 1.855.258.6455.



2023-24 Rates and Contributions

		Monthly Premium Rates	Monthly Employer Contribution	Employee Contribution per pay period
EPO	Employee Only	$660.65	$597.85	$28.99
	Employee + Spouse	$1,176.21	$880.05	$136.69
	Employee + Child	$984.47	$791.85	$88.90
	Employee + Family	$1,424.90	$1,024.17	$184.95
		Monthly Premium Rates	Monthly Employer Contribution	Employee Contribution per pay period
Buy Up EPO	Employee Only	$725.96	$630.22	$44.19
	Employee + Spouse	$1,293.08	$895.38	$183.55
	Employee + Child	$1,078.97	$805.43	$126.25
	Employee + Family	1,570.78	$1,017.07	$255.56
		Monthly Premium Rates	Monthly Employer Contribution	Employee Contribution per pay period
HDHP	Employee Only	$607.25	$605.82	$0.66
	Employee + Spouse	$1,077.48	$939.54	$63.69
	Employee + Child	$899.54	$811.60	$40.62
	Employee + Family	$1,307.27	$1,119.33	$86.77
		Monthly Premium Rates	Monthly Employer Contribution	Employee Contribution per pay period
Dental	Employee Only	$26.76	$2.76	$11.07
	Employee + Family	$76.04	$8.78	$31.04
		Employee Contribution per pay period		
Vision	Employee Only	$2.95		
	Employee + Spouse	$5.61		
	Employee + Child	$5.91		
	Employee + Family	$8.59		

For High Deductible Health Plan Members

Cochise County does contribute to your HSA Account

Maximum Contributions for 2023-24 Individual $3,850/Family $7,750

55+ may contribute an additional $1,000

See page 15 for more information on contributions and how the HSA works with your HDHP

Health Savings Accounts (HSA)

Administered by Health Equity

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

	Health Savings Account (HSA)
What medical plan can I choose?	High Deductible health Plan (HDHP)
Who administers the HSA	Health Equity www.healthequity.com
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses). https://www.irs.gov/publications/p969
When can I use the funds?	Funds are available as you contribute to the account
Can I roll over funds each year?	Yes, funds roll over from year to year and are yours to keep (even if you leave the County or retire)
How do I pay for eligible expenses?	With your Health Equity debit card
How much can I contribute each year?	$3,850 for individual coverage or $7,750 for family coverage in 2023. You may contribute additional funds to your HSA ($1,000 per tax year) if you will be 55 years or older by December 31. Learn more at: www.healthequity.com
Can I change my contributions throughout the year ?	Yes, please contact Human Resources to change your contribution.

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

What Are the Tax Implications of an HSA?

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

HSA Contributions

- Cochise County contributes $500 annually in bi-monthly contributions to your HSA.
- Members and Spouses on the medical plan can earn another $500 by participating in wellness activities. See page 24 for more information.
- Twice a year you have an opportunity to convert excess PTO into an HSA contribution of up to $500.

Flexible Spending Accounts (FSA)

Administered by Sheakley

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay for certain expenses on a pre-tax basis. As an eligible employee, you have the option to participate in an FSA by setting aside a portion of your pre-tax salary via payroll deductions. The amount you contribute to the FSA is not subject to social security (FICA), federal, state or local income taxes effectively lowering your annual taxable salary.

	Health Care FSA	Dependent Care FSA
What is it?	An account that allows you to set aside pre-tax dollars from each paycheck to pay for eligible medical, dental and vision expenses	An account that allows you to set aside pre-tax dollars from each paycheck to pay for a eligible child or elderly care expenses while you and your spouse work full time
What expenses are eligible?	You can use the funds to pay for qualified expenses such as: copayments, coinsurance, prescriptions, dental expenses, vision expenses etc. Types of expenses which may potentially be considered as qualified expenses can be found at: www.irs.gov/publications/p502/index.html	Daycare expenses for your tax-dependent children under age 13 or dependents who are mentally or physically incapable of caring for themselves (including elderly dependents).
When can I use the funds?	All of the funds you elect are available on the first day of the plan year	Funds are available as you contribute to the account with each paycheck
How do I pay for eligible expenses?	With your Sheakley debit card	Reimbursement from Sheakley
How much can I contribute each year?	You may contribute up to $3,050 to your healthcare FSA in 2023. This runs on a plan year basis	You may contribute up to $5,000 to your dependent care FSA in 2023. This runs on a plan year basis

How do I use it?

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

"Use it or Lose it" Rule

The health care FSA and dependent care FSA run on a plan year basis. The current plan year is from July 1, 2023 through June 30, 2024. Claims for reimbursement may only be made for services/expenses incurred during the 2023-24 plan year. Cochise County has elected to offer a carryover option for the health care FSA, which will allow you to carry over up to $570 or other dollar amount if less of unused contributions into the next plan year. Be conservative when making elections. Please refer to your plan documents for additional information.

All claims for reimbursement MUST be submitted no later than September 28, 2024 which is 90 days from end of plan year. Any funds left unclaimed after that date will be forfeited.

Dental Coverage

Administered by Ameritas

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

Preferred Provider Organization (PPO) Dental		
	In-Network	**Out-of-Network***
Annual Deductible (Individual/Family)	$50/$150	$100/$300
Annual Maximum (Per Person)	$2,000	$1,500
Preventive Care (Routine Cleaning and X-rays)	$0 deductible waived	20% after deductible
Basic Services (Fillings, Basic Root Canals, Periodontics, Extractions)	20% after deductible	50% after deductible
Major Services (Bridges, Dentures Crowns, Implants, Endodontics)	50% after deductible	60% after deductible
Orthodontia (Children up to age 18)	50% after deductible	50% after deductible
Orthodontia Lifetime Maximum (Per Person – Banded by age 17)	$2,500	$2,500

Coinsurance rates reflect the member responsibility percentage.

PPO Dentist: Payment is based on the PPO Dentist's allowable fee or the actual fee charged, whichever is less.

Out-of-Network Dentist: Payment is based on the non-participating Table of Allowance.
Members are responsible for the difference between the non-participating dentist Table of Allowance and the full fee charged by the dentist.

Finding a Network Dentist
1. Go to **www.ameritas.com** and click **Find a Health Provider** in the top menu.
2. Select **Find a Network Dental Provider Online**
3. Enter your search criteria and choose **Classic (PPO)** network. Click **Search**.
4. A list of results will display. If necessary, you can also narrow the results by name, distance, or specialty.
5. Or call 800.659.2223

Vision Coverage

Administered by EyeMed

Cochise County's vision plan covers routine eye exams and helps you pay for glasses or contact lenses. Dependents are eligible until their 26th birthday. Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages.

Find an EyeMed Provider

1. Register and log in to the member vision portal at EyeMed.com
2. Review your vision benefit information
3. Find a provider near you and schedule an appointment.

Just log in to the vison portal and select Find an eye doctor. Search by location, doctor, or Online & Lasik, select "Insight Network.".

40%OFF

additional complete pair of prescription eyeglasses

20%OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit & Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $105
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $30
Bifocal	$10 copay	Up to $50
Trifocal	$10 copay	Up to $70
Lenticular	$10 copay	Up to $70
Progressive - Standard	$65 copay	Up to $50
Progressive - Premium Tier 1 - 4	$95 - 185 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $23
Anti Reflective Coating - Premium Tier 1 - 3	$57 - 85 copay	Up to $23
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $105
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $105
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	**ALLOWED FREQUENCY – ADULTS**	**ALLOWED FREQUENCY – KIDS**
Exam	Once every plan year	Once every plan year
Frame	Once every plan year	Once every plan year
Lenses	Once every plan year	Once every plan year
Contacts Lenses	Once every plan year	Once every plan year

(Plan allows member to receive either contacts and frame, or frame and lens services)

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1] Based on weighted average of sample transactions: EyeMed Insight network/$10 exam copay/$10 materials copay/$120 frame or contact lens allowance.

Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor—search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

PDF-2004-M-377

Life and Accidental Death & Dismemberment Insurance

Administered by Ochs

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

	BASIC LIFE	**VOLUNTARY TERM LIFE**
Employee Benefit	Your employer provides full-time employees Basic Term Life coverage in the amount of your annual salary up to $50,000.	Elect in $10,000 increments up to $750,000
Accidental Death & Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage equal to one time the employee's life benefits.	Not available
Spouse Benefit *Coverage terminates when spouse reaches age 70*	Your spouse is eligible for coverage in the amount of $2,500.	Elect in $10,000 increments up to $250,000 not to exceed 100% of employee's total basic life & supplemental coverage
Child Benefit	Your dependent children are eligible for coverage in the amount of $2,500 ($250 birth to six months).	$10,000, $15,000 or $20,000 for each of your dependent children from live birth to age 26 not to exceed 100% of employee's totals basic and supplemental coverage combined.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount when you sign up for coverage during the initial enrollment period.	Basic Life is Guarantee Issue	New Hire Guarantee Issue coverage up to an additional $300,000 per employee, $50,000 for spouse and all child Voluntary Term Life. Amounts requested over guaranteed issue are subject to medical underwriting.
Premiums	Covered by Cochise County	Increase on plan anniversary after you enter the next 5-year age band.
Benefit Reductions	No age reduction for active employees.	No age reduction for active employees.
Please see the full certificate for additional information, options, and restrictions.		

Keep Your Beneficiaries Up to Date

- Make sure to keep this information updated so your benefit is paid according to your wishes.
- This may be done by completing a Beneficiary Designation form. See Human Resources to obtain the form.

Voluntary Life and AD&D Rates

securian FINANCIAL | Ochs

Employee and Spouse Supplemental Term Life Rates (based on age and 26 pay period)

Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*
Rate per $1,000	$0.023	$0.028	$0.037	$0.042	$0.055	$0.097	$0.171	$0.282	$0.346	$0.605	$0.951
Coverage Amount											
$5,000	0.12	0.14	0.19	0.21	0.28	0.49	0.86	1.41	1.73	3.03	4.76
$10,000	0.23	0.28	0.37	0.42	0.55	0.97	1.71	2.82	3.46	6.05	9.51
$20,000	0.46	0.56	0.74	0.84	1.10	1.94	3.42	5.64	6.92	12.10	19.02
$30,000	0.69	0.84	1.11	1.26	1.65	2.91	5.13	8.46	10.38	18.15	28.53
$40,000	0.92	1.12	1.48	1.68	2.20	3.88	6.84	11.28	13.84	24.20	38.04
$50,000	1.15	1.40	1.85	2.10	2.75	4.85	8.55	14.10	17.30	30.25	47.55
$60,000	1.38	1.68	2.22	2.52	3.30	5.82	10.26	16.92	20.76	36.30	57.06
$70,000	1.61	1.96	2.59	2.94	3.85	6.79	11.97	19.74	24.22	42.35	66.57
$80,000	1.84	2.24	2.96	3.36	4.40	7.76	13.68	22.56	27.68	48.40	76.08
$90,000	2.07	2.52	3.33	3.78	4.95	8.73	15.39	25.38	31.14	54.45	85.59
$100,000	2.30	2.80	3.70	4.20	5.50	9.70	17.10	28.20	34.60	60.50	95.10
$110,000	2.53	3.08	4.07	4.62	6.05	10.67	18.81	31.02	38.06	66.55	104.61
$120,000	2.76	3.36	4.44	5.04	6.60	11.64	20.52	33.84	41.52	72.60	114.12
$130,000	2.99	3.64	4.81	5.46	7.15	12.61	22.23	36.66	44.98	78.65	123.63
$140,000	3.22	3.92	5.18	5.88	7.70	13.58	23.94	39.48	48.44	84.70	133.14
$150,000	3.45	4.20	5.55	6.30	8.25	14.55	25.65	42.30	51.90	90.75	142.65
$160,000	3.68	4.48	5.92	6.72	8.80	15.52	27.36	45.12	55.36	96.80	152.16
$170,000	3.91	4.76	6.29	7.14	9.35	16.49	29.07	47.94	58.82	102.85	161.67
$180,000	4.14	5.04	6.66	7.56	9.90	17.46	30.78	50.76	62.28	108.90	171.18
$190,000	4.37	5.32	7.03	7.98	10.45	18.43	32.49	53.58	65.74	114.95	180.69
$200,000	4.60	5.60	7.40	8.40	11.00	19.40	34.20	56.40	69.20	121.00	190.20
$210,000	4.83	5.88	7.77	8.82	11.55	20.37	35.91	59.22	72.66	127.05	199.71
$220,000	5.06	6.16	8.14	9.24	12.10	21.34	37.62	62.04	76.12	133.10	209.22
$230,000	5.29	6.44	8.51	9.66	12.65	22.31	39.33	64.86	79.58	139.15	218.73
$240,000	5.52	6.72	8.88	10.08	13.20	23.28	41.04	67.68	83.04	145.20	228.24
$250,000	5.75	7.00	9.25	10.50	13.75	24.25	42.75	70.50	86.50	151.25	237.75
$260,000	5.98	7.28	9.62	10.92	14.30	25.22	44.46	73.32	89.96	157.30	247.26
$270,000	6.21	7.56	9.99	11.34	14.85	26.19	46.17	76.14	93.42	163.35	256.77
$280,000	6.44	7.84	10.36	11.76	15.40	27.16	47.88	78.96	96.88	169.40	266.28
$290,000	6.67	8.12	10.73	12.18	15.95	28.13	49.59	81.78	100.34	175.45	275.79
$300,000	6.90	8.40	11.10	12.60	16.50	29.10	51.30	84.60	103.80	181.50	285.30
$350,000	8.05	9.80	12.95	14.70	19.25	33.95	59.85	98.70	121.10	211.75	332.85
$400,000	9.20	11.20	14.80	16.80	22.00	38.80	68.40	112.80	138.40	242.00	380.40
$450,000	10.35	12.60	16.65	18.90	24.75	43.65	76.95	126.90	155.70	272.25	427.95
$500,000	11.50	14.00	18.50	21.00	27.50	48.50	85.50	141.00	173.00	302.50	475.50
$550,000	12.65	15.40	20.35	23.10	30.25	53.35	94.05	155.10	190.30	332.75	523.05
$600,000	13.80	16.80	22.20	25.20	33.00	58.20	102.60	169.20	207.60	363.00	570.60
$650,000	14.95	18.20	24.05	27.30	35.75	63.05	111.15	183.30	224.90	393.25	618.15
$700,000	16.10	19.60	25.90	29.40	38.50	67.90	119.70	197.40	242.20	423.50	665.70
$750,000	17.25	21.00	27.75	31.50	41.25	72.75	128.25	211.50	259.50	453.75	713.25

**Additional rates available upon request. Rates change according to age brackets.*

Additional Benefits

Employee Assistance Program

Supportlinc EAP will provide up to five (5) free counseling sessions each plan year (July 1 through June 30) for each type of issue you or any member of your household may encounter along with work-life assistance for financial and/or legal problems. These visits are completely confidential and are completely free to you and your household members *(not required to be on your Medical/Rx plan – just need to live in your household)*. To make a confidential appointment, please call 888-881-5462. You can also access a variety of information on their website at www.supportlinc.com. Brochures and more information are available in Human Resources.

In-the-moment support
Reach a licensed clinician by phone 24/7/365 for immediate assistance.

Financial expertise
Consultation and planning with a financial counselor.

Legal consultation
By phone or in-person with a local attorney.

Short-term counseling
Access up to **five (5) no-cost counseling sessions**, in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance abuse.

Convenience resources
Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.

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

Your web portal and mobile app
- The one-stop shop for program services, information and more.
- Discover on-demand training to boost wellbeing and life balance.
- Find search engines, financial calculators and career resources.
- Explore thousands of articles, tip sheets, self-assessments and videos.

Convenient, on-the-go support
- **Textcoach®**
  Personalized coaching with a licensed counselor on mobile or desktop.
- **Animo**
  Self-guided resources to improve focus, wellbeing and emotional fitness.
- **Virtual Support Connect**
  Moderated group support sessions on an anonymous, chat-based platform

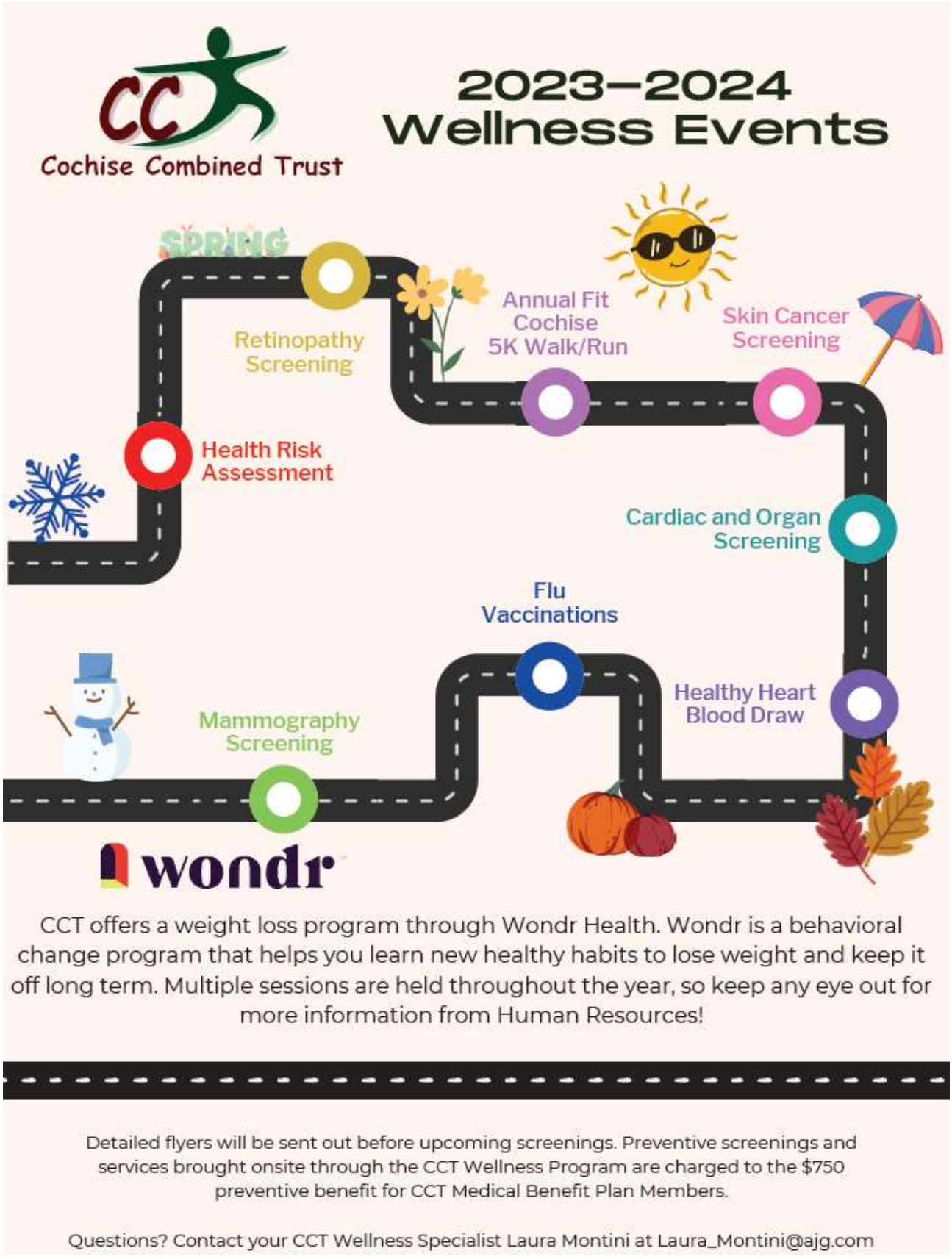
supportlinc EMPLOYEE ASSISTANCE

Download the mobile app today!

1-888-881-5462

supportlinc.com
group code:
cochisecombinedtrust

Wellness Events



Better Health Better Wealth Program

2023–2024 Cochise County High Deductible Health Plan Healthy Savings Account

CCT County members and spouses enrolled in the High Deductible Health Plan have the opportunity to earn up to $500 per year in additional employer-paid HSA account contributions by participating in wellness activities/events!

- ☐ Health Risk Assessment
- ☐ Nurse Consultation
- ☐ Skin Cancer Screening
- ☐ Flu Vaccinations
- ☐ Dental Cleaning
- ☐ Tobacco Cessation Program
- ☐ Wellness Survey
- ☐ Health Screening follow up
- ☐ Worksite Fitness Educational Presentation
- ☐ Retinopathy Screening
- ☐ Cardiac and Organ Screening
- ☐ Healthy Heart Blood Draw
- ☐ Mammogram Screening
- ☐ Worksite Fitness Enrollment
- ☐ Screening follow up
- ☐ Any organized physical event
- ☐ Healthy Lifestyle Log

Questions? Contact your CCT Wellness Specialist Laura Montini at Laura_Montini@ajg.com

wondr™

Cochise Combined Trust

CCT offers a weight loss program through Wondr Health. Wondr is a behavioral change program that helps you learn new healthy habits to lose weight and keep it off long term. Multiple sessions are held throughout the year, so keep any eye out for more information from Human Resources!

No Cost

Your employer offers Wondr at no-cost to you.

No Diet

No points, plans or counting calories —Wondr teaches you how to eat your favorite foods and still lose weight, get more physically fit, catch better ZZZs, and improve your overall health.

24/7 Support

Watch lessons, get resources, set up daily nudges, and chat with Wondr health coaches—anytime, anywhere, from the Wondr app.

Backed by Science

It's not a coincidence that Wondr ends in "dr." Founded by expert clinicians, Wondr is grounded in behavioral science with clinically-proven results that last.

Questions? Contact your CCT Wellness Specialist Laura Montini at Laura_Montini@ajg.com

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local Human Resources department.

Benefit	Vendor	Phone	Website or Email
Medical Claims Administrator	Ameriben	1.855.258.6455	www.Myameriben.com
Medical Network	Blue Cross Blue Shield of Arizona		www.azblue.com/chsnetwork
Telemedicine	Teladoc	1.800.835.2362	www.teladoc.com
Prescription	Navitus	1.866.333.2757	www.navitus.com
Dental	Ameritas	1.800.659.2223	www.ameritas.com
Vision	EyeMed	1.866.939.3633	www.eyemed.com
Health Savings Account	Health Equity	1.866.346.5800	www.healthequity.com
Flexible Spending Account	Sheakley	1.800.877.2053	www.sheakley.com
Life and AD&D	Ochs/Securian	1.800.392.7295	www.ochs@ochsinc.com
Employee Assistance Program	Supportlinc	1.888.881-5462	www.supportlinc.com

Name	Title	Phone	Email
Lisa Culp	Benefits Specialist	520.432.9706	lculp@cochise.az.gov
Brian Trevino	HR Generalist	520.432.9709	btrevino@cochise.az.gov

Legal Notices & Disclosures

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

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

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Cochise Combined Trust Plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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, 2023. Contact your State for more information on eligibility –

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

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=e n_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

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

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at 520.432.9700 or HumanResources@cochise.az.gov.

HIPAA SPECIAL ENROLLMENT RIGHTS

Cochise Combined Trust Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Cochise Combined Trust Plan. To actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction.

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources at 520.432.9700 or HumanResources@cochise.az.gov.

Important Warning

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

NOTICE OF CREDITABLE COVERAGE

Important Notice from Cochise Combined Trust About Your Prescription Drug Coverage and 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 Cochise Combined Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Cochise Combined Trust has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Cochise Combined Trust coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Cochise Combined Trust coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

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

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

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1 800-772-1213 (TTY 1-800-325-0778).

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

Date: July 1, 2023
Name of Entity/Sender: Cochise Combined Trust
Contact—Position/Office: Gallagher Benefit Services, Trust Administrator
Office Address: 1115 Stockton Hill Rd. Ste. 101
Kingman, AZ 86401
Phone Number: 928-753-4700

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

When is COBRA continuation coverage available?

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

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

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

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

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

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

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

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

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

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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

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

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

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

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

Plan contact information
Cochise Combined Trust
c/o Gallagher Benefit Services, Trust Administrator
1115 Stockton Hill Rd., Ste. 101 Kingman, AZ 86401

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Disclaimer

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

This document is an outline of the coverage provided by the Cochise Combined TrustTrust. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The Summary Plan Description and Plan Document must be read for those details.

Reminder: If you are not requesting changes to your current benefit elections no action is required. The exception is the Flexible Spending Account which requires participants to complete new paperwork annually.

If you have any questions, please contact Lisa Culp or Brian Trevino at HumanResources@cochise.az.gov or call

(520) 432-9700

Cochise Combined Trust, July 1, 2023 – June 30, 2024

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting