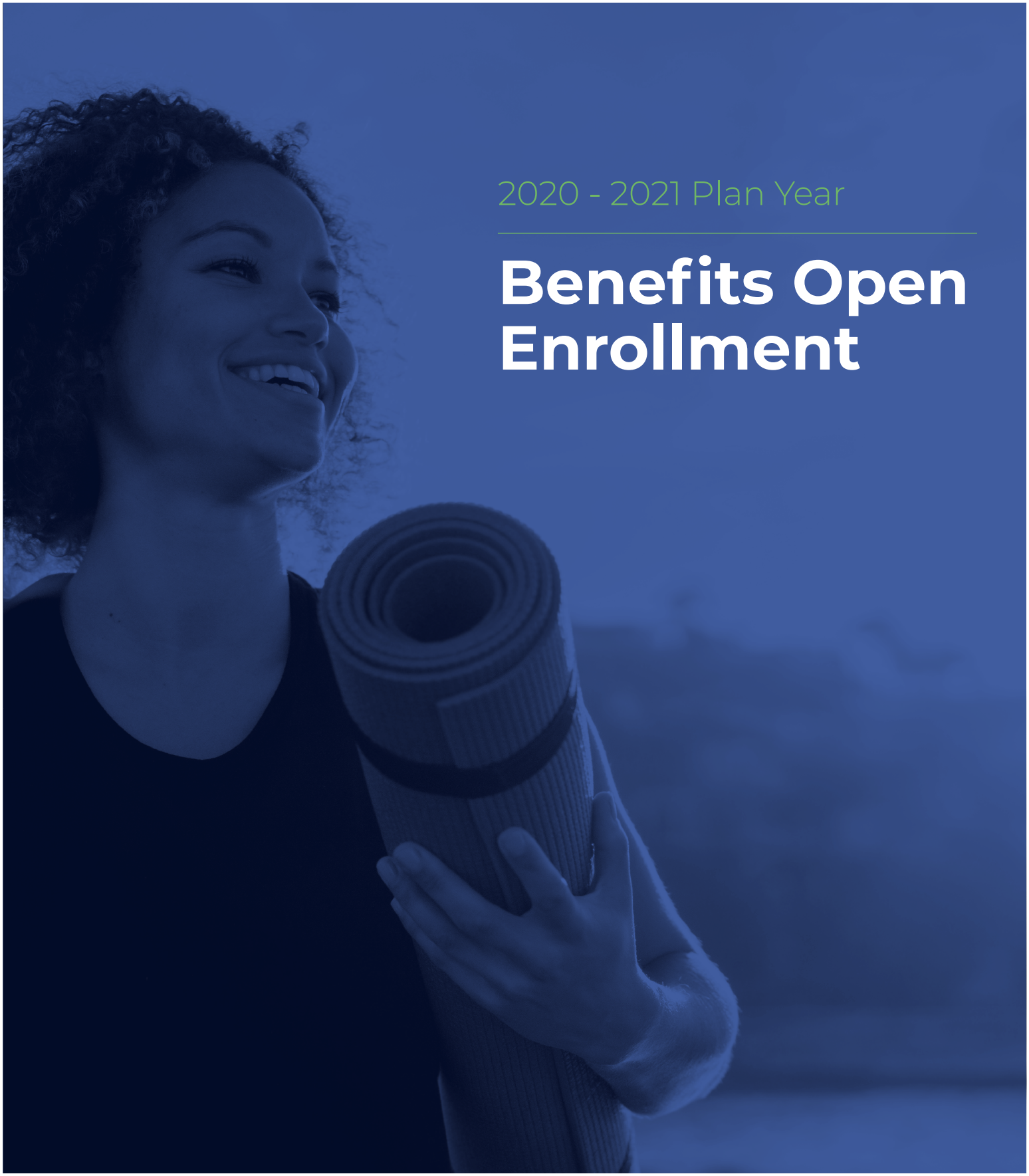

2020 - 2021 Plan Year

Benefits Open Enrollment

MARICOPA
COMMUNITY COLLEGES

BENEFIT VENDOR CONTACT INFORMATION

DESCRIPTION	VENDOR	GROUP #	PHONE	WEBSITE
Basic Life Insurance Supplemental Life Insurance Voluntary AD&PL	THE HARTFORD	805736	1-888-563-1124 (Option 5, Life Claims)	Contact Benefits Department
Short-Term Disability Insurance	MetLife	679054	1-800-769-4638	online.metlife.com
Precertification of Services	MERITAIN HEALTH An Aetna Company	14450	1-800-242-1199	N/A
Deferred Compensation Retirement Plan	TSA CONSULTING GROUP	403(b) 457(b)	1-888-796-3786	www.tsacg.com
Dental Insurance	MetLife	11777	1-800-942-0854	online.metlife.com
Employee Assistance Program	IBH	N/A	1-800-395-1616	www.ibhsolutions.com/members
Flexible Spending Accounts	MERITAIN HEALTH An Aetna Company	600368	1-800-566-9305	www.meritain.com
Dental Insurance	Sun Life Financial	907728	1-800-443-2995	www.sunlifeconnect.com
Health Concierge	alight	N/A	1-800-513-1667	member.alight.com
Medical Insurance	MERITAIN HEALTH An Aetna Company	14450	1-800-762-2234	www.meritain.com
Prescription Plan	Humana Pharmacy	N/A	1-877-559-2955	www.humana.com
24/7/365 Medical Care Access	TELADOC	N/A	1-800-362-2667	www.MyDrConsult.com
Vision Insurance	VSP Vision care for life	12261467	1-800-877-7195	www.vsp.com
Diabetes Management	Kannact	N/A	1-844-452-6622	www.kannact.com/mcccd/
In-network coverage outside of Arizona	First Health. Cofinity	N/A	1-800-226-5116	firsthealth.coventryhealth-care.com
Arizona State Retirement	ARIZONA STATE RETIREMENT SYSTEM	N/A	602-240-2000	www.azasrs.gov

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CHECKLIST

Open enrollment is the annual period to review your health care coverage and make changes, such as selecting or changing a new plan, adding eligible family members, or enrolling in other benefit plans. It's the only time you can make these changes unless you have a Qualified Life Event.

Use the following checklist to ensure your open enrollment goes smoothly:

*****NOTE: All benefit forms can be downloaded from the Benefits page in the Employee Portal.*****

- ☐ Review this booklet and the detailed information on the Benefits website to help you make your benefit choices.
- ☐ **Enrollment deadline is May 1, 2020 at 5:00 p.m.**
- ☐ Gather and submit all required supplemental paperwork (e.g. birth certificate, marriage license, etc.) to the District Office Benefits Department by **May 1, 2020 at 5:00 p.m.** Paperwork not received by the deadline will result in the cancellation of your election choice.
- ☐ If you are enrolling in a MCCCD Medical Plan, complete the mandatory Meritain Other Insurance Coverage Information form. It is available on the Benefits website as well as Meritain's member portal, where you can submit it online.

HEALTH CONCIERGE SERVICES - **ALIGHT**

MCCCD now offers health concierge services to help you navigate through the impossible world of healthcare. Alight can assist with finding doctors, understanding your insurance benefits, Medicare options, saving money on medical care and much more. You have access to a Health Pro consultant to help with all of your needs and questions related to healthcare.

Alight services are provided to you free of charge if you are covered under a MCCCD medical plan.

alight | COMPASS An Alight Company

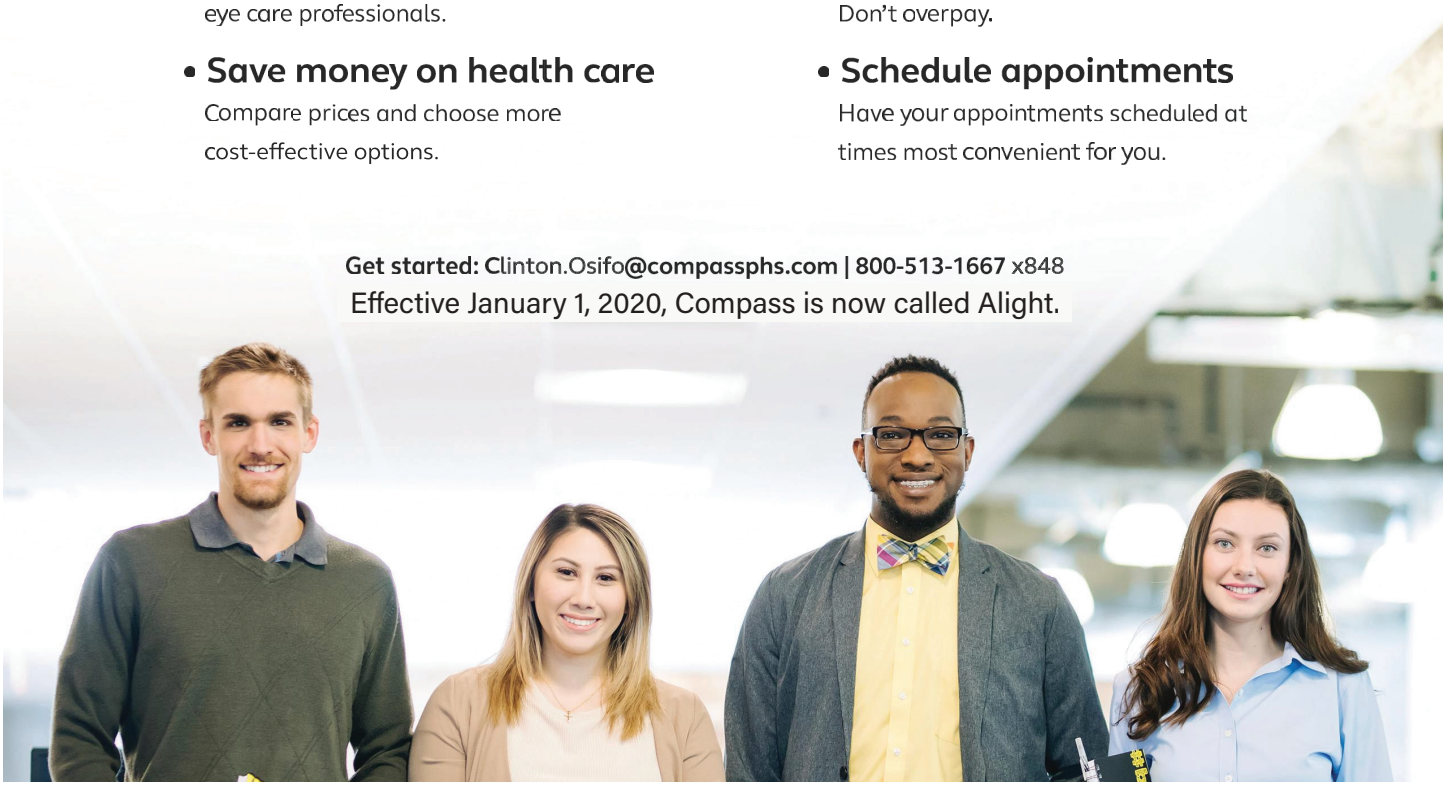
Take advantage of your benefit!

Health care costs are rising, benefits can be confusing and finding the right care can be frustrating and time-consuming. Don't worry! Help has arrived. You now have a personal Health Pro® consultant ready to assist you and your family.

- **Understand your benefits**
  Clear up any confusion about your health plan.
- **Find great doctors**
  Locate highly-rated doctors, dentists and eye care professionals.
- **Save money on health care**
  Compare prices and choose more cost-effective options.
- **Pay less for prescriptions**
  Get recommendations for lower-cost medications.
- **Resolve billing errors**
  Over 30% of medical bills are wrong. Don't overpay.
- **Schedule appointments**
  Have your appointments scheduled at times most convenient for you.

Get started: Clinton.Osifo@compassphs.com | 800-513-1667 x848

Effective January 1, 2020, Compass is now called Alight.



OPEN ENROLLMENT

April 13, 2020 – May 1, 2020 (5:00 p.m.)

No rate increases or plan design changes for 2020-2021!!

Deadline for changes and paperwork submission – May 1, 2020 at 5:00 p.m.

I'M NOT MAKING ANY CHANGES

We highly recommend you review your benefits to reconfirm you have the coverage needed for you and your family. You may wish to increase your short-term disability election by one step without providing Evidence of Insurability.

I'M WAIVING COVERAGE

To waive coverage, select Waive on the HCM Self-Service portal AND submit a completed waiver form to Rx@domail.maricopa.edu by 5:00 p.m. on May 1, 2020, or you will be automatically enrolled for core benefits.

Changes will not be allowed after May 1, 2020 at 5:00 p.m. unless you have a qualifying event (see list of qualifying events on benefits section of employee portal).

Deadline to enroll and submit your benefit elections online is May 1, 2020.

To access HCM:

1. Log into HCM with your MEID and Password
2. View your current elections: **Employee Self Service > Benefit Details > Benefits Summary**
3. Change or enroll in benefits: **Employee Self Service > Benefits > Benefits Enrollment**

***Verify personal information for yourself, all dependents and beneficiaries and update as needed.**

****Print a copy of your choices for your records.**

The new Benefit Year starts on July 1, 2020 – review your elections on July 2, 2020 and contact Benefits immediately if your elections are not correct.

Need extra help?

Please see the "HCM – Open Enrollment" Quick Reference Guide (QRG) on the employee portal.

NEED OPEN ENROLLMENT ASSISTANCE?

Benefits navigators with Complete Benefit Alliance (CBA) are supporting this year's Open Enrollment. Employees may conveniently schedule an appointment online and receive a call from the benefits navigator at the scheduled time. Benefits navigators will be able to answer basic questions about benefits options and the enrollment process. More complex questions will be forwarded to the MCCCD Benefits team for resolution.

Schedule your appointment with a benefits navigator today: **www.mymcccdbenefits.com**

WELLNESS MARICOPA

Maricopa Community Colleges values the health and well-being of its employees. Wellness Maricopa encourages employees to be engaged in their health by offering various Wellness programs. Wellness Incentive Credits are used to offset the cost of medical premiums.

Wellness 360

WELLNESS 360 This secure, HIPAA-compliant wellness portal helps you to:

- track your health behaviors
- complete a Personal Health Profile (PHP)
- review your biometric screening and health summary
- browse an expansive health library
- create a personal wellness plan
- track incentives and rewards
- register for events and challenges

natura)(yslim®

NATURALLY SLIM® Learn how to improve your health and manage your weight while eating the foods you love! This program will teach you how to modify your eating habits, conduct self-monitoring, and prevent relapses. Available to employees and to spouses or partners who are also on the MCCCD medical plan.

MAINTAIN. DON'T GAIN! Need help staying accountable for your weight over the holiday season? This annual program runs from mid-November to mid-January.

For further information regarding any of the wellness programs please refer to the Wellness 360 portal or the Wellness page in the Benefits section of the Employee Portal.

WELLNESS INCENTIVE CREDITS

All Benefit-Eligible employees who are covered by a Maricopa medical insurance plan are eligible for the following Wellness Incentive Credits, which will be paid out over 26 pay periods (18 pay periods for less than 12 month pay employees):

- $240 per fiscal year for participating in the biometric screenings
- $360 per year for a living tobacco-free lifestyle and testing negative for nicotine

MCCCD-sponsored annual biometric screening events for Spring 2020 are canceled.

CRITERIA TO RECEIVE WELLNESS INCENTIVE CREDITS FOR 2020-2021 YEAR

- Must be enrolled in a MCCCD medical insurance plan for FY 2020 - 2021
- Must have participated in a Biometric Screening Event in 2019 or as a new employee in 2020. **Employees who participated in a 2019 Biometric Screening Event are not required to participate in one in 2020.**
- Must login to Wellness 360 and update their Personal Health Profile by May 15, 2020. https://maricopa.learn.taleo.net/files/upload/tts/other/My_Wellness_360_Dashboard_QRG.pdf

Employees who satisfy these criteria will receive Wellness Incentive Credits for FY 2020 - 2021 at the same level as FY 2019 - 2020.

2020 NEW EMPLOYEES

If you are a new employee and completed a biometric screening after January 1, 2020, you will automatically roll over into the FY2020 - 2021 plan as long as you stay on MCCCD health insurance. You do not need to complete biometrics or update your PHP.

If you have additional questions, contact your College Wellness Coordinator:

https://maricopa.sharepoint.com/sites/DO/human-resources/benefits/Pages/wellness.aspx or email: Wellness.Maricopa@domail.maricopa.edu

2020 - 2021 BENEFITS COST SUMMARY

MEDICAL PLANS	EMPLOYEE COST Per Pay Check (26 Pay Periods)	EMPLOYEE COST Per Pay Check (18 Pay Periods) (less than 12 month pay employees)
CORE PLAN (EPO)		
Employee Only	$0.00	$0.00
Employee and Spouse	$32.02	$46.25
Employee and Child(ren)	$19.93	$28.79
Employee and Family	$84.92	$122.33
BUY UP PLAN (PPO)		
Employee Only	$14.78	$21.35
Employee and Spouse	$116.57	$168.38
Employee and Child(ren)	$90.30	$130.43
Employee and Family	$192.09	$277.46

DENTAL PLANS

SUNLIFE DENTAL PLAN		
Employee Only	$5.34	$7.71
Employee and Spouse	$9.03	$13.04
Employee and Child(ren)	$12.52	$18.08
Employee and Family	$14.78	$21.35
METLIFE PLAN (CO-PAY)		
Employee Only	$9.10	$13.14
Employee and Spouse	$18.51	$26.74
Employee and Child(ren)	$22.75	$32.86
Employee and Family	$34.68	$50.09
METLIFE PLAN (PDP)		
Employee Only	$30.06	$43.42
Employee and Spouse	$63.21	$91.30
Employee and Child(ren)	$67.74	$97.85
Employee and Family	$74.96	$108.28

VOLUNTARY POLICIES

The costs for Supplemental Term Life, Accidental Death & Personal Loss, Long Term Care, and Short Term Disability insurances are based on the coverage amount selected. See the Supplemental Insurance cost page for current premiums.

MEDICAL PLANS - **MERITAIN HEALTH**

Meritain Health provides the following administrative services for both MCCCD medical plans:

- Medical and behavioral health claims processing and precertification
- Explanation of Benefits (EOB) statements
- Customer service regarding medical plans
- Issuance of Medical ID cards

MCCCD wants you to get the appropriate care, when and where you need it. That's why our medical plan includes the extra expertise of **Meritain Health's Medical Management**.*

The Medical Management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering with a focus on:

- The recommended treatment for your health condition.
- The proposed location of your treatment.
- The proposed length of stay at that location.
- The cost-effectiveness of your treatment and setting.

**You and your doctor always have the right to appeal a decision made by the Medical Management team if you disagree with their decision. A panel of doctors will review the appeal.*

For more information about Meritain Health and instructions on how to register on the Meritain Health Member Portal, refer to the Benefits section of the Employee Portal.

Employees enrolled in medical coverage have access to the following tools on Meritain's website and mobile app:

- Verify eligibility and benefits coverage
- Search for providers
- Check claims status
- Explanation of benefits documents
- View benefit plan documents
- View deductibles and out-of-pocket limits
- Submit Coordination of Benefits information
- Request Letter of Coverage
- Download and view a copy of your medical insurance card
- And much more...

MEDICAL PLANS - **COMPARISON CHART**

MERITAIN HEALTH
An Aetna Company

	CORE (EPO) PLAN		BUY-UP (PPO) PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible	$750 per person $1,500 family maximum	Not Covered	$500 per person $1,000 family maximum	$1,500 per person $3,000 family maximum
Plan Year Out-of-Pocket Maximum	$5,000 per person $10,000 per family (Including deductibles, co-pays & RX)	Not Covered	$3,750 per person $7,500 per family (Including deductibles, co-pays & RX)	$9,000 per person $18,000 per family (Including deductibles, co-pays & RX)
Lifetime Maximum	Unlimited	Not Covered	Unlimited	Unlimited
Preventive Services	Covered 100%	Not Covered	Covered 100%	Not Covered
Primary Care Provider Office Visit Copay	$25	Not Covered	$15	Deductible + 50% Coinsurance
Specialist Office Visit Copay	$40	Not Covered	$30	Deductible + 50% Coinsurance
ER Facility Copay (Copay waived if admitted)	$200	Not Covered	$200	$200
ER Attending Physician and Other Provider Services Cost	80% coinsurance, deductible waived	Not Covered	85% coinsurance, deductible waived	85% coinsurance, deductible waived
Ambulance	Deductible + 80% Coinsurance	Not Covered	Deductible + 85% Coinsurance	Deductible + 85% Coinsurance
Urgent Care Copay	$45	Not Covered	$35	Deductible + 50% Coinsurance
Retail Pharmacy Copay: 30 day supply	$10/ $30/ $75 generic/ formulary/ nonformulary	Not Covered	$7/ $20/ $60 generic/ formulary/ nonformulary	Not Covered
Mail Order Copay: 90 day supply (2xs Copay)	$20/ $60/ $150 generic/ formulary/ nonformulary	Not Covered	$14/ $40/ $120 generic/ formulary/ nonformulary	Not Covered
Inpatient Hospital Copay	$300 + Deductible + 80% Coinsurance, if pre-certified	Not Covered	$300 + Deductible + 85% Coinsurance, if pre-certified	$300 + Deductible + 50% Coinsurance
Outpatient Hospital	Deductible + 80% Coinsurance, if pre-certified	Not Covered	Deductible + 85% Coinsurance, if pre-certified	Deductible + 50% Coinsurance
Laboratory/Pathology/ Radiology	Deductible + 80% Coinsurance	Not Covered	Deductible + 85% Coinsurance	Deductible + 50% Coinsurance
Chiropractic Office Visits	$40 per visit	Not Covered	$30 per visit	Deductible + 50% Coinsurance

This is a partial summary of the medical plans.
A complete listing of all plan information can be found on the Benefits section of the Employee Portal.

PRESCRIPTION BENEFITS - **HUMANA**

Humana Pharmacy

The prescription drug benefit for MCCCD employees is administered by Humana Pharmacy Solutions.

HOW TO GET THE MOST FROM YOUR BENEFIT PLAN

To get the most from your benefits plan, it pays to be a wise consumer. In many cases, you can control how much your share of costs will be when you fill a prescription.

Generic drugs cost less to manufacture and they are just as effective as the brand-names. You will save money when you request them because generics have a lower co-pay than preferred or non-preferred drugs.

	CORE (EPO) PLAN		BUY-UP (PPO) PLAN	
	In Network	Out-of-Network	In-Network	Out-of-Network
Retail (30-day supply)				
Generic drugs	$10	N/A	$7	N/A
Preferred brand-name drugs	$30	N/A	$20	N/A
Non-preferred brand name drugs	$75	N/A	$60	N/A
Mail Order (90-day supply)				
Generic drugs	$20	N/A	$14	N/A
Preferred brand-name drugs	$60	N/A	$40	N/A
Non-preferred brand name drugs	$150	N/A	$120	N/A

HOW GENERIC DRUGS MEASURE UP TO BRAND NAMES

- Cost up to 75% less
- Subject to same FDA testing
- Contain the same active ingredients
- Come in identical dosages

For more information on Humana or for instructions on how to register for MyHumana refer to the Benefits section of the Employee Portal.

HUMANA RESOURCES AVAILABLE

- Retail - 90 day supply available for three co-pays except for specialty
- MyHumana web portal and mobile app
- Drug Pricing Tool and List Search
- Patient Assistance Program Information
- Rx Calculator
- Pharmacy Locator
- Drug Dictionary and Interactions Information
- Alternative Medicine Encyclopedia
- Antibiotics and Immunizations Tips

DENTAL PLANS - **SUNLIFE DENTAL**

PLAN HIGHLIGHTS

This dental plan can help lower your out-of-pocket expenses so you and your family can maintain healthy smiles and better overall health.

- Each family member must choose an in-network Plan Dentist prior to receiving services
- Access to a range of dental services from in-network providers at fixed copayment amounts
- No claims to file for Plan Dentists and Plan Specialists
- No deductibles and no annual dollar maximums for Plan Dentists and Plan Specialists
- Benefits are payable for pre-existing dental conditions within the copayment schedule
- Extensive Provider Network that is updated regularly
- Copayments and discounts for specialty care
- Online Dental Health Center
- Mobile app available
- Dental mobile app contains virtual coverage card. No physical card will be issued.

Procedure Type	Copayment General Dental	Copayment Specialist
Office Visit	No Charge	N/A
Periodic Oral Evaluation	No Charge	N/A
Bitewings x-rays - 4 films	No Charge	N/A
Routine Cleaning - Adult	No Charge	N/A
Routine Cleaning - Child	No Charge	N/A
Resin-Based Composite (tooth-colored fillings)		
1 surface - Posterior	$60	N/A
2 surfaces - Posterior	$68	N/A
3 surfaces - Posterior	$75	N/A
Crowns and Pontics		
Crown - Porcelain fused to high noble metal	$245	N/A
Crown - Full cast high noble metal	$245	N/A
Crown - (Bridge abutment) Porcelain fused to high noble metal	$245	N/A
Pontic - Porcelain fused to high noble metal	$245	N/A
Root Canals		
Anterior	$115	N/A
Bicuspid	$245	$400
Molar	$305	$600

*Additional charges for services may apply

To see a complete description of the plan, list of services and copayments, refer to the Benefits section of the Employee Portal.

DENTAL PLANS - **METLIFE**

PLAN HIGHLIGHTS

- Freedom of choice to go to any dentist (in-network and out-of-network coverage).
- Additional savings if you use in-network providers.
- Preventive exams and cleanings are covered in full without having to meet deductible.
- Easy access to pre-treatment estimates, real-time claims processing and 24 hour customer service by phone, fax or online.
- Dental mobile app contains virtual coverage card. No physical card will be issued.
- Oral fitness online library
- Large and constantly growing network with participating dentists that must meet rigorous standards.

	METLIFE PDP/INDEMNITY (Plan 1)		METLIFE CO-PAY (Plan 2)	
Coverage Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Type A - Preventive (cleanings, oral examinations)	100% of Negotiated Fee	100% of R&C* Fee	See Schedule	70% of Negotiated Fee
Type B - Basic Restorative (fillings)	90% of Negotiated Fee	75% of R&C* Fee	See Schedule	40% of Negotiated Fee
Type C – Major Restorative (bridges and dentures)	60% of Negotiated Fee	45% of R&C* Fee	See Schedule	25% of Negotiated Fee
Type D – Orthodontia	50% of Negotiated Fee	50% of R&C* Fee	50% of Negotiated Fee	50% of Negotiated Fee
Deductible+				
Individual	$50	$100	N/A	$50
Family	$100	$200	N/A	$100
Annual Maximum Benefit				
Per Person	$5,000	$5,000	$1,000	$750
Orthodontia Lifetime Maximum Per Person	$2,000	$2,000	$1,000	$1,000

Reasonable and Customary (R&C) fees are calculated based on the lowest of 1) the dentist's actual charge, 2) the dentist's usual charge for the same or similar services or the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

To see a complete description of the plan, list of services and copayments, refer to the Benefits section of the Employee Portal.

VISION BENEFITS - **VSP**

Employees enrolled in our medical plan will enjoy a full-service vision plan, which includes a comprehensive eye exam and eyewear through the VSP Choice plan!

VISION BENEFIT HIGHLIGHTS

- $180 to spend on contacts or $150 for contact lenses
- Progressive lenses covered in full with $40 copay
- Review vision benefits, eligibility and coverage information at VSP.com
- No ID card necessary
- Exclusive Member Extras, special offers and additional savings on lens enhancements
- Access to the Premier Program

YOUR COVERAGE WITH A VSP PROVIDER			
BENEFIT	**DESCRIPTION**	**COPAY**	**FREQUENCY**
WellVision Exam	Focuses on your eyes and overall wellness	$15 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $180 allowance for a wide selection of frames • $200 allowance for featured frame brands • 20% savings on the amount over your allowance • $100 Costco© frame allowance	Combined with exam	Every 24 months
Lenses	• Single vision, lined bifocal and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	• Progressive lenses • Average savings of 20-25% on other lens enhancements	$40	Every 12 months
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eyecare plus Program	• Services related to diabetic eye disease, glaucoma andage-related macular degeneration (AMD). Retinalscreening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP providerwithin 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

For more information on the VSP benefit, including costs for Out-of-Network Providers, refer to the Benefits section of the Employee Portal.

SUPPLEMENTAL INSURANCE

SUPPLEMENTAL TERM LIFE INSURANCE

This is a voluntary, employee-paid supplemental term life insurance policy. Supplemental life insurance coverage is portable, so if you leave employment, you can take this coverage with you.

Coverage in the amount of $20,000 is provided by MCCCD at no cost to the employee.

Dependent coverage or additional coverage may be purchased during open enrollment at the rates listed below.

- New elections of life insurance (outside of new employee enrollment) or an increase in coverage requires Evidence of Insurability (EOI) and is subject to approval by The Hartford.
- EOI forms must be submitted directly to The Hartford and can be found on the Employee Portal in the Benefits section.
- Elected coverage in the amounts of $5,000 - $30,000 is pre-tax.
- All other coverage is taxable.

SUPPLEMENTAL TERM LIFE INSURANCE EMPLOYEE COVERAGE		
COVERAGE AMOUNT	**COVERAGE INCREMENTS**	**RATES PER PAY PERIOD**
$5,000 - $50,000	$5,000	See Supplemental Life Rate Chart *(below)*
$50,000 - $100,000	$25,000	
$150,000 - $300,000	$50,000	
$300,000 - $500,000	$100,000	

SUPPLEMENTAL TERM LIFE INSURANCE DEPENDENT COVERAGE		
COVERAGE AMOUNT	**YOUR COST** (26 PAY)	**YOUR COST** (18 PAY)
$5,000	$0.91	$1.31
$10,000	$1.81	$2.61
$15,000	$2.72	$3.93
$20,000	$3.63	$5.24
$25,000	$4.54	$6.56

SUPPLEMENTAL LIFE RATE CHART

HOW TO USE THIS CHART

To determine pay period cost:

1. Select the total amount of coverage you want
2. Divide by 1,000
3. Multiply that number by the rate shown on the chart for your age

****COVERAGE REDUCTIONS:**
Age 70: to 50%

EMPLOYEE AGE	RATE
Less than 25	0.017
25 - 29	0.018
30 - 34	0.024
35 - 39	0.031
40 - 44	0.043
45 - 49	0.064
50 - 54	0.098
55 - 59	0.169
60 - 64	0.210
65 - 69	0.291
70 - 74	0.404
75 - 79	0.560
80 - 99	0.687

SUPPLEMENTAL INSURANCE

ACCIDENTAL DEATH & PERSONAL LOSS INSURANCE

Accidental Death & Personal Loss (ADPL) covers losses you or your covered dependents, suffer solely and as a direct result of an accidental bodily injury that occurs while covered by the plan.

THE HARTFORD

Coverage in the amount of $15,000, is provided by MCCCD at no cost to the employee.

Dependent coverage or additional coverage may be purchased during open enrollment at the rates listed below. Benefit coverage reduces at age 70 to 50%.

NUMEROUS BENEFITS, INCLUDING:

- 100% of the amount of coverage purchased in the event of accidental loss of life, loss of both feet, both hands, sight in both eyes or loss of both speech and hearing in both ears.
- 70% for accidental loss of one limb.
- 50% for accidental loss of one hand, one foot, sight in one eye or loss of speech or hearing in both ears.
- 25% for accidental loss of thumb and index finger of the same hand.

EMPLOYEE ONLY		
COVERAGE AMOUNT	YOUR COST (26 PAY)	YOUR COST (18 PAY)
$25,000	$0.29	$0.42
$50,000	$0.58	$0.84
$100,000	$1.15	$1.66
$150,000	$1.73	$2.50
$200,000	$2.31	$3.34
$250,000	$2.88	$4.16
$300,000	$3.46	$5.00
$350,000	$4.04	$5.84
$400,000	$4.62	$6.67
$450,000	$5.19	$7.50
$500,000	$5.77	$8.33

EMPLOYEE AND DEPENDENTS		
COVERAGE AMOUNT	YOUR COST (26 PAY)	YOUR COST (18 PAY)
$25,000	$0.35	$0.51
$50,000	$0.69	$1.00
$100,000	$1.38	$1.99
$150,000	$2.08	$3.00
$200,000	$2.77	$4.00
$250,000	$3.46	$5.00
$300,000	$4.15	$5.99
$350,000	$4.85	$7.01
$400,000	$5.54	$8.00
$450,000	$6.23	$9.00
$500,000	$6.92	$10.00

SUPPLEMENTAL INSURANCE

METLIFE SHORT-TERM DISABILITY

This is a voluntary, employee-paid short-term disability (STD) policy through MetLife. This disability policy is payable weekly if you are unable to work due to a non-occupational illness or injury.

HIGHLIGHTS:

- Employees are eligible to receive a monthly benefit in addition to any MCCCD accrued leave.
- Elected amounts range from $250 to $4,000 per month.
- Elected amounts may not exceed 66 2/3% of your base salary.
- STD benefit payments start after fourteen (14) consecutive days of disability and may continue up to ninety (90) days.
- Can increase your current election by one step without providing Evidence of Insurability.
- During open enrollment you may increase your election by one step without providing Evidence of Insurability.
- Evidence of Insurability is required for more than one step or enrolling during Open Enrollment for any amount.

For more information please visit the Benefits section of the Employee Portal.

SHORT-TERM DISABILITY RATE CHART			
ANNUAL SALARY	**MONTHLY COVERAGE**	**YOUR COST** (26 PAY)	**YOUR COST** (18 PAY)
$4,500	$250	$0.52	$0.75
$7,200	$400	$0.83	$1.20
9,900	$550	$1.14	$1.65
$12,600	$700	$1.45	$2.10
$15,300	$850	$1.77	$2.55
$18,000	$1,000	$2.08	$3.00
$20,700	$1,150	$2.39	$3.45
$23,400	$1,300	$2.70	$3.90
$26,100	$1,450	$3.01	$4.35
$28,800	$1,600	$3.32	$4.80
$31,500	$1,750	$3.63	$5.25
$34,200	$1,900	$3.95	$5.70
$36,900	$2,050	$4.26	$6.15
$39,600	$2,200	$4.57	$6.60
$42,300	$2,350	$4.88	$7.05
$45,000	$2,500	$5.19	$7.50
$47,700	$2,650	$5.50	$7.95
$50,400	$2,800	$5.82	$8.40
$53,100	$2,950	$6.13	$8.85
$55,800	$3,100	$6.44	$9.30
$58,500	$3,250	$6.75	$9.75
$61,200	$3,400	$7.06	$10.20
$63,900	$3,550	$7.37	$10.65
$66,600	$3,700	$7.68	$11.10
$69,300	$3,850	$8.00	$11.55
$72,000	$4,000	$8.31	$12.00

SUPPLEMENTAL INSURANCE

Trustmark
benefits beyond benefits

Trustmark Universal Life/LifeEvents® Insurance with Long-Term Care Benefit

Two choices for combined coverage and lifelong protection.

Trustmark Universal Life is **two-in-one security**. It combines **permanent life insurance** with benefits that can help with the high costs of long-term care services. It helps protect your family from the financial impact of losing a loved one or needing extended care. You select a benefit amount that works for you, and you **"lock in" a rate** that is designed to last a lifetime and doesn't increase due to age. The Universal LifeEvents option adjusts to your changing needs as you age. For the same rate, it provides a **higher death benefit** during your working years, when you may need the protection most. The death benefit then reduces after age 70.1 You also get a higher benefit for long-term care that remains at the same high level.

For a $50,000 policy, your benefits might pay like this:

$50,000	You can collect **4%** of your benefit amount per month for up to **25 months** to help pay for long-term care services.
+$50,000	Plus, if you collect benefits for LTC, your **full death benefit** can still be paid to beneficiaries.
+$50,000	Plus, you can extend your benefits for LTC an **extra 25 months**, up to 50 total months. (Optional benefit.)
$150,000	**Total maximum benefit!**

For the same dollar amount, you can purchase more coverage with Life Events:

Universal Life Events	Death Benefit	Living Benefits
Before Age 70	$50,000	$50,000
After Age 70[1]	$16,667	$50,000

Universal Life	Death Benefit	Living Benefits
Before Age 70	$31,016	$31,016
After Age 70	$31,016	$31,016

Benefits for long-term care begin to pay after 90 days of confinement or services; to qualify you must meet conditions of eligibility for benefits. Benefit amounts shown are for sample plans and are not a guarantee.

Trustmark Hospital StayPay® Insurance

Keeping things balanced when you get knocked off your feet.

Hospital stays can be **really expensive**, and health insurance might not cover everything. You may have copays, deductibles and other surprise expenses. Trustmark Hospital StayPay **helps you keep a hospital trip affordable**. It's designed to **pair with your medical plan** so you can be more confident in your protection. You can get **cash benefits** for hospital stays due to a covered sickness or accident, normal childbirth or mental wellness/addiction recovery. You also have flexibility to **adjust your benefit** amount as your needs change. With Hospital StayPay, you can worry less about your bills, and focus on recovering.

SCHEDULE OF BENEFITS

First Day Stay Benefit	$1,000
Daily Hospital Stay Benefit	$150
Daily Hospital ICU Benefit	$300
Additional features	
Childbirth Hospital Stay	Included
Claim Free Return	$100

†Benefits marked with this symbol are designed to be compatible with Health Savings Accounts (HSAs). However, anyone who has or plans to open an HSA should consult tax and legal advisors to confirm which supplemental benefits may be purchased by persons with an HSA to maintain tax-exempt status.

[1]Universal LifeEvents death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary; issue age is 18-64. • Plan forms GUL.205/IUL.205, HII 119, and applicable riders are underwritten by Trustmark Insurance Company, Lake Forest, Illinois. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Benefits, availability, exclusions and limitations may vary by state and may be named differently. Pre-existing condition limitations may apply. For exclusions and limitations that may apply, visit trustmarkbenefits.com/Voluntary-Benefits/Disclosures/UL and trustmarkbenefits.com/Voluntary-Benefits/Disclosures/HSP. Your policy/certificate will contain complete information. Trustmark®, LifeEvents®, and Trustmark Hospital StayPay® are registered trademarks of Trustmark Insurance Company.

SUPPLEMENTAL SERVICES

EVEREST FUNERAL PLANNING AND CONCIERGE SERVICE

- 24/7 Advisor Planning Assistance (1-800-913-8318)
- Online Planning Tools and access to Everest PriceFinderSM Reports

www.everestfuneral.com/hartford Enrollment Code: **HFEVLC**

IBH SOLUTIONS EAP (EMPLOYEE ASSISTANCE PROGRAM)

Counseling Resources

- 24-hour Crisis Help
- In-Person Counseling
- Online Consultations

Work-Life Resources

- Financial Services
- Legal Services
- Mediation Services
- Online Legal Forms
- Identity Theft Services

THE MINUTE CLINICS, THE LITTLE CLINICS & TAKE CARE CLINICS

- The clinics are available for you and your covered dependents to use (PCP office visit benefit applies).
- Clinics offer convenient, no-appointment needed options for treatment by a licensed physician's assistant or nurse practitioner for non-emergency medical conditions

See the Benefits section of the Employee Portal for more information on these benefits.

RETIREMENT SAVINGS PLAN

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN

The 403(b) and 457(b) Plans are valuable retirement savings options available to MCCCD employees. This section provides a brief explanation of the provisions and rules that govern the 403(b) and 457(b) Plans offered.

Please note you may enroll in these plans at any time not only during open enrollment.

Plan administration services for the 403(b) and 457(b) plans are provided by TSA Consulting Group, Inc. (TSACG). Visit the TSACG website (tsacg.com) for information about enrollment in the plan, investment product providers available, distributions, exchanges or transfer, 403(b) and/or 457(b) loans, and rollovers.

Eligibility

Most employees are eligible to participate in the 403(b) and 457(b) plans immediately upon employment, however, private contractors, appointed/elected trustees and/or school board members and student workers are not eligible to participate in the 403(b) Plan. Employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans. Participants are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Traditional 403(b) and 457(b)

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) and/or 457(b) account(s) up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) and 457(b) accounts are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

Roth 403(b)

Contributions made to a Roth 403(b) account are after-tax deductions from your paycheck. Income taxes are not reduced by contributions you make to your account. All qualified distributions from Roth 403(b) accounts are tax-free. Any earnings on your deposits are not taxed as long as they remain in your account for five years from the date that your first Roth contribution was made. Distributions may be taken if you are age 59½ (subject to plan document provisions) or at separation from service.

The basic contribution limit for 2020 is $19,500.

Employees who are 50 or older by Dec.31 2020, may contribute an additional $6,000 above the basic 2020 annual limit of $19,500 for a total of $26,000.

PLAN ADMINISTRATOR CONTACT INFORMATION
Toll-free: 1-888-796-3786 | Toll-free fax: 1-866-741-0645 | www.tsacg.com

MARICOPA COMMUNITY COLLEGES

KANNACT IS A FREE NEW BENEFIT FOR DIABETES MANAGEMENT

FREE DIABETES TESTING SUPPLIES ARE DELIVERED TO YOUR DOOR AS NEEDED

A WIRELESS GLUCOMETER UPLOADS BLOOD GLUCOSE READINGS TO YOUR PRIVATE PORTAL AUTOMATICALLY

PERSONALIZE AN ACTION PLAN BASED ON YOUR LIFESTYLE WITH INSIGHT FROM A CERTIFIED DIABETES COACH

A MOBILE APP THAT IS CUSTOMIZABLE TO YOUR NEEDS

Living with diabetes can be overwhelming. Managing diabetes alone can drain your time, energy, and relationships. That's why we're offering Kannact to you. Kannact gives you the tools and support needed to self-manage your diabetes. Kannact helps lower blood glucose levels, and participants have reported improved activity levels, weight loss, enriched family relationships and an overall better quality of life.

Enroll at:

www.kannact.com/maricopa

Kannact
www.kannact.com

24/7/365 MEDICAL CARE ACCESS - **TELADOC**

TELADOC™

How long are you waiting for quality medical care?

Why wait for the care you need now? Teladoc® gives you 24/7/365 access to a doctor through the convenience of phone or video consults. You can feel better today and **avoid the hassles of the hospital waiting room.**

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Skin problems
- Respiratory infection
- Sinus problems
- And more!

WITHOUT THE WAIT

Teladoc has a national network of experienced doctors, which means you don't need to wait in line for care.

16 min
AVG CALL BACK TIME

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for Free

Teladoc.com
Facebook.com/Teladoc
1-800-DOC-CONSULT (362-2667)
Teladoc.com/mobile

FINAL INFORMATION AND REMINDERS

HOW HEALTHCARE REFORM AFFECTS YOUR PLAN:

In March 2010, President Obama signed the Affordable Care Act, or ACA, into law. The ACA, also known as health care reform, includes certain consumer protections that apply to your health plan, for example, the requirement for the provision of preventive health services without any cost sharing.

Questions regarding how healthcare reform affects your plan can be directed to Meritain Health at 1.800.762.2234. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1.866.444.3272 or online at: www.dol.gov/ebsa/healthreform

Healthy balance for your family, too

Your family members can also reap the rewards of our benefit plan. Healthcare benefits are available for every eligible dependent. It's a great way to help your family members find the right balance between life's "roller-coaster ride" and their best health. Be sure your family knows about the opportunities open to them.

Eligible Dependents include:

- Your spouse or domestic partner
- Children under the age of 26 including step children, your partner's children, and adopted children
- **Excluded from the benefit coverage provided by MCCCD** are brothers, sisters, parents, grandparents, grandchildren, aunts, uncles, ex-spouses, ex-partners, children of ex-spouses and ex-partners. However, medical support orders for children will qualify for eligibility.

You must notify the benefits department if your dependent is no longer eligible for coverage in our benefit plan.

See the Benefits section on the Employee Portal for information and rules regarding dependents.

If you say "no" to coverage now

You have the right to not enroll in the MCCCD benefit plan, but please review what we have to offer and weigh the pros and cons of such a decision.

IMPORTANT: If you don't enroll now, you will have to wait for your employer to offer an open enrollment period, which is held annually. If you have a "Qualifying Event" you will be allowed to enroll outside of the open enrollment period provided that:

1. You have notified us within 30 days of the "Qualifying Event" **and**
2. You have submitted all of the required documentation to MCCCD Benefits Department

For more information on what is considered a "Qualifying Event" please refer to the Benefits section of the Employee Portal.

REQUIRED SUPPLEMENTAL PAPERWORK

ALL supplemental paperwork (including waivers) referred to in this booklet can be found on the Benefits section of the Employee Portal (https://ep.maricopa.edu/hr/benefits)

Please note the deadline to submit **ALL** supplemental paperwork is **May 1, 2020 at 5:00PM.**

***Note some forms are required to be sent to the vendor directly, please follow instructions on the forms.**

ANNUAL NOTICES

SUMMARY OF BENEFITS AND COVERAGE (SBC)
Enclosed in your Open Enrollment packet you will find a document called a Summary of Benefits and Coverage, commonly referred to as a "SBC". This SBC provides a brief overview of the medical plan benefits provided by Maricopa Community Colleges. You will want to review this and share it with your other family members who enroll for coverage.

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 you understand and compare medical benefits.

What the SBC Contains
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. Government regulations are very specific about the information that can and cannot be included in each SBC. Plan sponsors are not allowed to customize very much of the SBC. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages the SBC should be (maximum 4-pages), the font size, the colors used when printing the SBC and even which words were to be bold. An SBC includes:

- A health plan comparison tool called "Coverage Examples." The coverage examples illustrate how the medical plan covers care for two common health scenarios: having a baby and diabetes care. The examples show the projected total costs associated with each of these two situations, how much of these costs the Plan covers and how much you, the participant, needs to pay. In these examples, it's important to note that the costs are national averages; and do not reflect what the actual services might cost in your area. Plus, the cost for your treatment might also be very different depending on your doctor's approach, whether your doctor is an In-Network PPO Provider or a Non-PPO Provider, your age and any other health issues you may also have. These examples are there to help you compare how different health plans might cover the same condition - not for predicting your own actual costs.
- A link to a "Glossary" of common terms used in describing health benefits, including the words "deductible," "co-payment," and "co-insurance." The glossary is standard and cannot be customized by a Plan.
- Websites and toll-free phone numbers you can contact if you have questions or need assistance with benefits.

PATIENT PROTECTION NOTICE
The medical plans offered by MCCCD do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider. You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PPO network at their website: http://www.azblue.com/CHSNetwork.aspx

PRE-EXISTING CONDITION LIMITATIONS
Pre-existing condition limitations will no longer apply to MCCCD medical plans as of 07/01/2014.

NO RETROACTIVE CANCELLATION OF COVERAGE
In accordance with the requirements of the Health Care Reform Act, the MCCCD medical plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

WOMEN'S HEALTH AND CANCER RIGHTS ACT
The Women's Health and Cancer Rights Act of 1998 requires group health plans and health insurance issuers that cover mastectomies to also cover re-constructive surgery or other related services following a mastectomy.

Medicare HICN and Dependent Social Security Number Mandate
Social Security Numbers, or qualified alternate identification numbers, are required for all covered dependents due to the requirements of the implementation of Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. Medicare Health Insurance Claim Numbers (HICN), if applicable, must be submitted to the District Employee Benefits Department.

Non-Eligible Dependents and the Change in Status Rule
Only qualified dependents are eligible for coverage under your benefit plans provided by MCCCD. Qualified dependents include your spouse or domestic partner and your children, step children and adopted children under age 26. Excluded from the benefit coverage provided by MCCCD are brothers, sisters, parents, grandparents, grandchildren, aunts uncles, ex-spouses, ex-partners, children of ex-spouses and ex-partners. However, medical support orders for children will qualify for eligibility. It is a fraudulent practice to add ineligible dependents to MCCCD provided benefit coverage and disciplinary action will be taken, up to and including termination, should this occur.

If you have a change in family status, you must notify and submit all required documentation to the Benefits Department (HR Administration) within 30 days of the qualifying event. A qualified event include such examples as: birth, adoption, marriage, domestic partnership, divorce, death or a child reaching age 26.

Special Enrollment Rights
Effective April 1, 2009, special enrollment rights apply in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, which funds and expands the State Children's Health Insurance Program (SCHIP). The rights will apply if 1) you or your dependents experience a loss of eligibility for Medicaid or your SCHIP coverage; or 2) you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium. In order to be entitled to the special enrollment right, the employee must request coverage within 60 days of coverage termination or the date the parent or child is determined to be eligible for assistance.

CREDITABLE COVERAGE DISCLOSURE NOTICE
Yearly notice about your MCCCD prescription drug program and Medicare will be mailed to your home address in October. Please contact Meritain Health if you need this notice prior to October.

HIPAA REGULATIONS
The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Service issued the privacy Rule to implement the requirement of Health Insurance Portability and Accountability act of 1996 (HIPAA).

MCCCD maintains a HIPAA Notice of Privacy Practices describing how health information about individuals covered under our insurance plans may be used and disclosed.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1)Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2)Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
2. Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
5. Make available PHI in accordance with section 164.524 of the privacy standards;
6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;
7. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, sub-part E, of the privacy standards;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a)The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b)In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctionss hall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1)The Plan documents have been amended to incorporate the above provisions; and

(2)The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing

a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA's standards for security (the "security standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1)Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

(2)Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

(3)Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.

(4)Report to the Plan any Security Incident of which it becomes aware.

(5)The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

BENEFITS SELECTION NOTES

We have provided the following space for you to make notes regarding your benefits choices. You may find this sheet helpful to you when you login to the system to enroll or make changes in your benefits, as you will have all the information on one page.

MARICOPA
COMMUNITY COLLEGES

BENEFITS DEPARTMENT
2411 W. 14th Street
Tempe AZ 85281

480-731-8492 | 480-731-8484
rx@domail.Maricopa.edu
http://hr.maricopa.edu/benefits