

2017-2018 OPEN ENROLLMENT BENEFIT GUIDE



- MEDICAL/RX
- DENTAL
- VISION
- FSA/HSA
- LIFE / AD&D



Who is Eligible?

All active employees in accordance with the established policy of Cochise College and the Cochise Combined Trust are eligible for benefits provided they occupy a budgeted, benefited position as defined by the College, and are performing all of the duties of their employment. Retirees may also be eligible for components of the plan. For a list of eligible dependents, please refer to the Summary Plan Document.

How to Enroll

The first step is to review your current benefit elections, verify your personal information and determine if any changes are necessary. You only have to complete a new enrollment form if you are making changes to your existing coverage.



Turn your forms in to Human Resources on either the Douglas or Sierra Vista Campuses. For questions, please contact the Benefits Manager on the Sierra Vista Campus in room 315 during regular business hours (520.515.5308).

Any changes to dependent eligibility will require proof of eligibility (i.e., marriage and/or birth certificate, etc.). Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

Enrollment/Change Deadline

This year's open enrollment period is from **April 3, 2017** to **April 28, 2017**. This is the time period set aside for you to make changes to your benefit elections. The benefit changes you elect during open enrollment will become effective July 1, 2017.

Qualified Changes in Status

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. For a list of qualifying change of status situations, please refer to the Summary Plan Document.

What's New for 2017-18?

Medical

The following changes to the Medical benefits will be effective for the upcoming plan year beginning **July 01, 2017 for the EPO Plan:**

- Added a National Wrap Network – You will now have access to the PHCS Healthy Directions Network **outside** of Arizona. Locate an out-of-network provider at www.multiplan.com/search/ (then select Multiplan logo)
- Coverage added for Diagnostic 3D Mammograms
- Increased the single out-of-pocket maximum from \$3,000 to \$3,500 and the family out-of-pocket maximum from \$13,700 to \$14,300 inclusive of deductibles and co-pays as required by the Affordable Care Act;
- Increased the deductible from \$350/\$1050 to \$500/\$1500
- Sleep studies and Advanced Imaging (i.e. CT scan, MRI/MRA, nuclear medicine, Pet scan) now require pre-certification
- An EPO Buy-up Plan has been added - \$250/\$750 deductible and \$2,000/\$4,000 maximum out-of-pocket. All other plan provisions remain the same. There is an additional employee contribution to participate in this plan.

Exclusive Provider Organization (EPO) Plan (Available to Active Employees and Eligible Retirees)

When you enroll in the EPO, benefits are payable only to contracted Blue Cross Blue Shield of Arizona (BCBSAZ) providers or PHCS Healthy Directions Providers outside of Arizona, except in the case of a life-threatening emergency. Members will pay a set co-payment for services as outlined in the summary plan document, such as doctor's office visits (\$25 Primary Care Physician or \$35 Specialist) and prescriptions. Before the plan's benefits take effect, you must meet the plan year deductible of \$500 per individual and \$1,500 for family and \$250 individual \$750 family for the EPO Buy-up plan. *Co-payments do not apply to the deductible.*

Co-insurance is the percentage of eligible expenses that members and the plan share when care is received. The plan pays 80% and you as the member pay 20% *after the individual or family deductible has been met.* You are responsible for your share of co-insurance until reaching the plan year out-of-pocket maximum. The out-of-pocket maximum is the most you will pay for eligible services during the plan year. When you reach the maximum, the plan pays 100% for eligible major medical services for the remainder of the plan year. The out-of-pocket maximum is \$3,500 per individual and \$14,300 for a family (\$2,000/\$4,000 EPO Buy-up). Your deductible and medical co-payments accumulate toward the maximum out-of-pocket. Please see prescription drugs section for information on prescription co-pays and prescription out-of-pocket maximums

To obtain Pre-certification and Verification of Benefits, members should call AmeriBen at 800-388-3193. ***If a plan participant fails to comply with the pre-certification requirements, it will result in a three hundred-dollar (\$300) penalty.*** Please refer to your summary plan document to see what services require pre-certification.



The following changes to the Medical benefits will be effective for the upcoming plan year beginning **July 01, 2017 for the High Deductible Health Plan (HDHP)** (This plan available to Active College Employees Only)

- Coverage added for Diagnostic 3D Mammograms
- Sleep studies and Advanced Imaging now require pre-certification
- A HDHP Buy-up Plan has been added with a \$1,300/\$2,600 deductible Co-insurance after deductible is 90/10 and \$3,000/\$6,000 maximum out-of-pocket. All other plan provisions remain the same. There is an additional contribution to participate in this plan.

Under the HDHP, members must meet the plan year deductible before the plan benefits kick in. You may use your Health Savings Account (HSA) funds to pay for any qualified medical expenses, including those incurred while meeting your deductible. If you exhaust your HSA funds, you pay any additional expenses required to meet your deductible out of your own pocket. Medical care and prescriptions are both subject to *the* deductible in this plan. The in-network deductible is \$3,000 for an individual and \$6,000 for a family and the *separate* out-of-network deductible is \$5,000 for an individual and \$10,000 for a family. ***Please note that if you have elected employee only coverage, the \$3,000 individual deductible must be met before the plan will begin to pay for ANY benefits except preventive care. If you elect family coverage, once any one member reaches \$3,000 in eligible expenses, the plan will begin to pay for their covered expenses; any combination of family members can meet the family deductible of \$6,000.*** Once you have met *the applicable in-network or out-of-network* deductible, your care is covered through the plan's co-insurance as outlined in the summary plan document. The plan pays 100% of eligible charges for services provided in-network and 50% of eligible charges for services provided out-of-network.

If you select the **HDHP Buy-up Plan** the in-network deductible is \$1,300 for an individual and \$2,600 for a family and the *separate* out-of-network deductible is \$5,000 for an individual and \$10,000 for a family. ***Please note that if you have elected employee only coverage, the \$1,300 individual deductible must be met before the plan will begin to pay for ANY benefits except preventive care. If you elect family coverage, the plan will begin to pay for covered expenses once the \$2,600 family deductible has been met.*** Once you have met *the applicable in-network or out-of-network* deductible, your care is covered through the plan's co-insurance as outlined in the summary plan document. The plan pays 90% of eligible charges for services provided in-network and 50% of eligible charges for services provided out-of-network until you reach the maximum out-of-pocket.

You are responsible for your share of co-insurance until reaching the plan's out-of-pocket maximum. The out-of-pocket maximum is the most you will pay for eligible services during the plan year. Once you reach the maximum, the plan will pay 100% of eligible charges. The out-of-pocket maximum for in-network services is \$3,000 for an individual and \$6,000 for a family; out-of-network is \$5,000 individual and \$10,000 family. The out-of-pocket maximums include the deductible and co-insurance.

Participants in the HDHP are eligible to contribute to a health savings account.



Health Savings Account (HSA)

What is an HSA?

An HSA is an individual savings account that can be used to pay for qualified medical expenses. The HDHP option allows you to open an HSA and take advantage of terrific tax savings. The money in your account accumulates on a tax-deferred basis and can be rolled over from year to year. You can save your money for future medical expenses, and as long as you use the money for a qualified medical expense, your funds are never taxed. This account is only available if you select the High-Deductible Health Plan (HDHP). A participant cannot contribute to an HSA if they are covered on any other non-qualified plan, are covered as a dependent on another person's tax return (excluding spouses), are enrolled in an FSA, or are enrolled in Medicare.

How Does an HSA Work?

The contributions that you elect to make are on a pre-tax basis to your HSA account. You will receive a debit card to use for qualified medical expenses, which will draw from your HSA. Distributions from your HSA are tax-free when used to pay for qualified medical expenses. The 2017 maximum contribution for single coverage is \$3,400, and family is \$6,750. HSA participants who are 55 or older can contribute an additional \$1,000, or \$4,400 for single coverage and \$7,550 for family coverage. There is a \$2.95 per month account fee.

Prescription Drugs

CCT is implementing the following changes to the prescription medication program effective July 1, 2017 for the *EPO* plan:

- Decrease the prescription maximum out-of-pocket from \$3,850 to \$3,650 for an individual. (The family maximum out-of-pocket is \$14,300 and includes both medical and prescription.)

The high deductible health plan (HDHP) prescription drug benefit is subject to the plan year deductible of \$3,000 for an individual and \$6,000 for a family. There are no co-payments, co-insurance or separate deductible for prescription drugs. The HDHP Buy-up prescription drug benefit is subject to the plan year deductible of \$1,300 for an individual and \$2,600 for a family. After the deductible, there is 90/10 co-insurance until the maximum out-of-pocket has been met. There are no co-payments or separate deductibles for prescription drugs.

Prescription Out-of-Pocket (OOP) Maximums

	EPO Base Plan	EPO Buy Up	HDHP Base	HDHP Buy Up
Individual	\$3,650	\$3,650	Prescription drug charges apply to Medical OOP	Prescription drug charges apply to Medical OOP
Family	Applies to Medical OOP limit of \$14,300	\$7,700	Prescription drug charges apply to Medical OOP	Prescription drug charges apply to Medical OOP

Dental Insurance

- Coverage for Orthodontia has been increased from \$1,000 lifetime to \$2,500 lifetime.

Voluntary Vision Insurance

- Allowance for Elective Contacts has been increased from \$120 to \$150
- Allowance for Eyeglass Frames has been increased from \$120 to \$150

To find an in-network provider for vision services, log onto the website at <https://www.eyemedvisioncare.com/locator> and choose the EyeMed Select Plan or call customer service at 1-866-939-3633

Group Voluntary Life Insurance

There are no changes to the *voluntary life insurance* benefit for the 2017-18 plan year. *However, premium rates are adjusted on 7-1-2017 for the employee and spouses that move into a new age band. If you, your spouse or children are not enrolled or if you wish to increase amounts you may complete an application; however, evidence of insurability will be required.* For benefits and rate information, please refer to the handout provided separately or call Human Resources. Open Enrollment is an excellent time to review your beneficiary designation to determine if any changes should be made.

Employee Assistance Program (EAP)



Cochise Combined Trust has selected a new Employee Assistance Program vendor. The College now provides an Employee Assistance Program through Alliance Work Partners (AWP). The EAP provides up to three (3) free counseling sessions each plan year (July 1 through June 30) for each type of problem you *or your household members* may encounter along with work-life assistance for financial and/or legal problems. To make a confidential appointment, please call 800-343-3822. You can also access a variety of information on their website at www.awpnow.com. Brochures and more information are available in Human Resources.

Teladoc

The College provides access to Teladoc for quick and convenient consultations with a physician. **Each plan participant in the EPO plan will receive two (2) consultations at a \$0 consultation fee.** Due to IRS regulations HDHP cannot receive the \$0 consultations but are still encouraged to utilize Teladoc with the \$45 fee for convenience. HDHP plan participants can receive reimbursement for consultations after meeting their deductible. Visit www.teladoc.com or call 1-800-Teladoc (835-2362) to set up your account and talk to a doctor.

Flexible Spending Accounts

Under Section 125 of the IRS code, the College sponsors a pre-tax cafeteria plan known as a Flexible Spending Account (FSA). This plan provides you with a convenient way to pay for certain expenses with pre-tax dollars' savings from FICA, federal, and sometimes even state taxes. Through the plan, *the College offers you the opportunity to participate in the following flexible spending accounts:*

1. **Unreimbursed Medical (URM) Account** – Employees may elect to participate in the unreimbursed medical account which is a cost-effective way to pay for predictable, eligible health care expenses that comply with the rules defined by the IRS. Such expenses typically are items not covered by health care insurance, such as co-payments for doctor visits and prescriptions. By paying for these expenses through an FSA before federal, social security, and state taxes are taken out, your taxable income is reduced. The maximum medical reimbursement amount allowable in FY 2017-18 is \$2,600.

Debit card is available for the URM account, the cost for the card is \$18.00 annually, or \$0.75 per pay period.

The debit card is available to employees that enroll in the Healthcare FSA (URM) and is not available to dependent care FSA (DDC) accounts).

Reimbursement of medical expenses incurred in any plan year must be within the sixty (60) days after the end of the plan year. There is an allowance for carryover of unused Health Care Flexible Spending Account funds at the end of each plan year, up to, but not to exceed \$500. The carryover funds must be unused Health Care Flexible Spending Account funds and can be used for qualified medical expenses.

NOTE: If you enroll in the HDHP and enroll in a Health Savings Account you are not allowed to enroll in the Health Care Flexible Spending Account.

2. **Dependent Day Care (DDC) Account** - Employees may also elect to participate in the dependent day care account which allows them to pay for dependent care expenses with tax-free dollars for eligible dependents. Maximum annual amount is \$5,000 or \$2,500 if married filing separately. Dependent Daycare eligible expenses are for children under the age of 13 and dependents of any age who are physically or mentally unable to care for themselves. By enrolling in this plan, you save money on daycare expenses incurred so that you (and your spouse, if married) can work, look for work, or attend school on a full-time basis.

As a reminder, you **must re-enroll** in the medical reimbursement or Dependent Day Care plan each year. Contact Linda Nichols for the appropriate enrollment forms.

Reminder: No forms are required to be completed this year unless you are requesting changes to your current benefit elections.

If you want to enroll in Flexible Spending or Health Savings, you MUST complete the appropriate enrollment forms.

If you have any questions, please contact Linda Nichols at nicholsl@cochise.edu or call (520)515-5308.

Employee & Employer Premium Contributions

New rates effective July 1, 2017 are:

	Employee	EE +Spouse	EE +Children	EE +Family
EPO Health Plan				
EPO College Monthly Rate	\$574.19	\$1,004.63	\$836.91	\$1,222.17
College Monthly Contribution	\$574.19	\$574.19	\$574.19	\$574.19
Employee Monthly Cost	\$0.00	\$430.44	\$262.72	\$647.98
Employee Pay Period Deduction	\$0.00	\$215.22	\$131.36	\$323.99

	EPO Health Plan <u>Buy Up</u> Option			
EPO College Monthly Rate	\$598.64	\$1,048.30	\$872.24	\$1,276.65
College Monthly Contribution	\$574.19	\$574.19	\$574.19	\$574.19
Employee Monthly Cost	\$24.45	\$474.11	\$298.05	\$702.46
Employee Pay Period Deduction	\$12.23	\$237.06	\$149.03	\$351.23

	High Deductible Health Plan (HDHP)			
HDHP College Monthly Rate	\$529.79	\$922.39	\$765.91	\$1,124.43
College Monthly Contribution	\$574.19	\$574.19	\$574.19	\$574.19
HSA College Monthly Contribution	\$44.40	\$0.00	\$0.00	\$0.00
Employee Monthly Cost	\$0.00	\$348.20	\$191.72	\$550.24
Employee Pay Period Deduction	\$0.00	\$174.10	\$95.86	\$275.12

	High Deductible Health Plan (HDHP) <u>Buy Up</u> Option			
HDHP College Rate	\$604.82	\$1,055.93	\$873.20	\$1,291.87
College Monthly Contribution	\$574.19	\$574.19	\$574.19	\$574.19
HSA College Monthly Contribution	\$0.00	\$0.00	\$0.00	\$0.00
Employee Monthly Cost	\$30.63	\$481.74	\$299.01	\$717.68
Employee Pay Period Deduction	\$15.32	\$240.87	\$149.51	\$358.84

	Dental Plan (no change)			
Dental College Monthly Rate	\$26.31	N/A	N/A	\$74.60
College Monthly Contribution	\$26.31	N/A	N/A	\$26.31
Employee Monthly Cost	\$0.00	N/A	N/A	\$48.29
Employee Pay Period Deduction	\$0.00	N/A	N/A	\$24.15

	Vision Plan (no change)			
Vision Employee Cost	\$6.40	\$12.16	\$12.80	\$18.62

Retiree premium rates are available upon request; please contact the Benefits Manager in Human Resources.

Wellness Program

Cochise Combined Trust is going back to basics for the 2017-18 Wellness programming. The Humana (Go365) program will be discontinued effective June 30, 2017. Your Go365 Bucks must be redeemed no later than June 30, 2017.



On-site Screenings will continue to be offered and a new and improved Health and Wellness quarterly newsletter will be coming your way.

Participation is the key to a successful Wellness Program and the key to a better quality of life for those who participate. Take the time to check out the Wellness Program being offered to you and your dependents as CCT participants. It is good for your health!

2017 – 18 Wellness Calendar of Events	
Month	Wellness Event
August 2017	Healthy Heart Draw
September 2017	Cardiac & Organ Screenings
	Flu & Pneumonia Vaccinations
October 2017	Mammograms
	Men's Health Exams
January 2018	Wellness Survey
March 2018	Health Risk Assessments/Biometric Screening
April 2018	8 th Annual Fit Cochise 5K
May 2018	Skin Cancer Screenings

**Take
care of
Yourself**!

The above wellness events are anticipated to be scheduled in the month listed above, however changes may occur.

The text contained in the Open Enrollment Benefit Guide was taken from the summary plan document and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this guide and the actual plan documents, the actual documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about open enrollment, please contact your Benefits Representative.



April 3 – April 28, 2017

Open Enrollment Meeting Schedule

Monday	Tuesday	Wednesday	Thursday	Friday
3	4	5	6	7
1– 2 PM SIERRA VISTA ROOM 303			7:30 – 8:30 AM DOUGLAS, Bldg 2000 FACILITIES CONFERENCE RM 11 -12 PM DOUGLAS ROOM 501 A & B	1 – 2 PM SIERRA VISTA ROOM 901 COCHISE CONNECT INCLUDES ITV WITH DOUGLAS BENSON, WILLCOX, ZOOM ON YOUR COMPUTER
10	11	12	13	14
	7:30 – 8:30 AM SIERRA VISTA ROOM 303		3– 4 PM SIERRA VISTA ROOM 303	9:30 -10 30 AM DOUGLAS ROOM 501 A & B
17	18	19	20	21
9 AM – 10 AM FORT HUACHUCA EDUCATION CENTER		11– 12 PM – SIERRA VISTA ROOM 903 COCHISE CONNECT INCLUDES ITV WITH DOUGLAS BENSON, WILLCOX, ZOOM ON YOUR COMPUTER		
24	25	26	27	28
	10:30 -11 30 AM DOUGLAS ROOM 501 A & B			8:30 – 9:30 AM SIERRA VISTA ROOM 303

[Click here to Register to attend an Open Enrollment meeting](#)

Important Notices

Women’s Health and Cancer Rights Act (WHCRA)

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:

1. all stages of reconstruction of the breast on which the *mastectomy* was performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance; prostheses
3. treatment of physical complications of the *mastectomy*, including lymphedema

This coverage is subject to the same *deductibles* and *co-payments* consistent with those established for other benefits under this *Plan*.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444- EBSA (3272).

If you live in the following State, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.

State	Website	Phone
Arizona • CHIP	http://www.azahcccs.gov/applicants	(Outside of Maricopa Co.): 1-877-764-5437 (Maricopa Co.): 1-602-417-5437

To research the availability of, and your eligibility for, premium assistance in other states, or for more information on special enrollment rights, you can contact either:

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

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

Compliance with HIPAA Privacy Standards

HIPAA stands for the *Health Insurance Portability and Accountability Act of 1996*.

Certain members of the *employer's* workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the *Privacy Standards*), these *employees* are permitted to have such access subject to the following:

1. **General.** The *Plan* shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this Compliance with *HIPAA Privacy Standards* section is met. Protected Health Information shall have the same definition as set out in the *Privacy Standards* but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the *employer's* workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The *Plan's* administrative functions shall include all *Plan* payment and health care operations. The terms payment and health care operations shall have the same definitions as set out in the *Privacy Standards*, but the term payment generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill *Plan* responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. Health care operations generally shall mean activities on behalf of the *Plan* that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. *Genetic information* will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the *employer's* workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this Compliance with *HIPAA Privacy Standards* section, members of the *employer's* workforce shall refer to all *employees* and other persons under the control of the *employer*.
 - a. **Updates Required.** The *employer* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - b. **Use and Disclosure Restricted.** An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the *Plan*.
 - c. **Resolution of Issues of Noncompliance.** In the event that any member of the *employer's* workforce uses or discloses Protected Health Information other than as permitted by the *Privacy Standards*, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised
 - ii. applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment
 - iii. mitigating any harm caused by the breach, to the extent practicable
 - iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages
4. **Certification of Employer.** The *employer* must provide certification to the *Plan* that it agrees to:

- a. Not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law.
 - b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the *Plan*, agrees to the same restrictions and conditions that apply to the *employer* with respect to such information.
 - c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *employer*.
 - d. Report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - e. Make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the *Privacy Standards*.
 - f. Make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the *Privacy Standards*.
 - g. Make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the *Privacy Standards*.
 - h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *Privacy Standards*.
 - i. If feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 information unfeasible.
 - j. Ensure the adequate separation between the *Plan* and member of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the *Privacy Standards*.
5. The following members of the Cochise Combined Trust are designated as authorized to receive Protected Health Information from the Cochise Combined Trust (the *Plan*) in order to perform their duties with respect to the *Plan*:
- a. Account Manager (brokerage firm)
 - b. Group Benefits Analyst (brokerage firm)
 - c. Assistant Vice President – Human Resources
 - d. Human Resources Director
 - e. Benefits Coordinator

Compliance with HIPAA Electronic Security Standards

Under the *Security Standards* for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the *Security Standards*), the *employer* agrees to the following:

1. The *employer* agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the *employer* creates, maintains or transmits on behalf of the *Plan*. Electronic Protected Health Information shall have the same definition as set out in the *Security Standards*, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

The *employer* shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Authorized Employees and Certification of Employers provisions, described above.

Mental Health Parity

Under a Federal law known as the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is self-funded by the *employer*, rather than provided through a health insurance policy. The Cochise Combined Trust (CCT) has elected exemption from the following requirement:

Parity in the Application of Certain Limits to Mental Health Benefits

Group health plans [of employers that employ more than fifty (50) employees] that provide both medical and surgical benefit and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the *Plan*.

The exemption from this Federal requirement will be in effect for the plan year beginning July 1, 2017 and ending June 30, 2018. This election may be renewed for subsequent plan years.

If you have any questions regarding CCT's election to exempt the Trust from the requirements of mental health parity, please feel free to contact the Pool Administrator, Stephanie Moore with Erin P. Collins & Associates, Inc., at (928) 753-4700 ext. 303.