CITY OF PHOENIX

BENEFITS GUIDE

2019

COBRA

OPEN ENROLLMENT IS

OCT. 22ND TO NOV. 9TH

CITY OF PHOENIX

2019 COBRA PREMIUM RATES

COVERED: TERMINATION, RETIREE, DIVORCE,

LOA-NON EMPLOYEE HEALTH AND CHILD REACHING AGE 26

EFFECTIVE JANUARY 1, 2019

MEDICAL		
Plan Choices	**Coverage**	**Monthly COBRA Rate**
Banner/ Aetna HMO	**SINGLE**	$530.07
	FAMILY	$1682.76
BlueCross/BlueShield PPO	**SINGLE**	$569.77
	FAMILY	$1808.79
BlueCross/BlueShield Savers Choice Health Plan	**SINGLE**	$442.80
	FAMILY	$1405.70

DENTAL		
Plan Choices	**Coverage**	**Monthly COBRA Rate**
Cigna Dental HMO	**SINGLE**	$27.87
	FAMILY	$76.81
Cigna Dental PPO	**SINGLE**	$51.39
	FAMILY	$141.65
Cigna Dental PPO Plus	**SINGLE**	$56.68
	FAMILY	$156.23

VISION		
Plan Choices	**Coverage**	**Monthly COBRA Rate**
AVESIS Vision Plan 1	**SINGLE**	$11.63
	FAMILY	$27.40

CITY OF PHOENIX

2019 COBRA PREMIUM RATES FOR

LOA- PERSONAL HEALTH & MILITARY- PRESIDENTIAL CALL UP

EFFECTIVE JANUARY 1, 2019

MEDICAL				
Plan Choices	Coverage	Monthly COBRA Rate 20% (months 1-12)	Monthly COBRA Rate 102% (months 12-18)	Monthly COBRA Rate 150%- SSDI (months 19-29)
Banner/ Aetna HMO	EMPLOYEE	$103.92	$530.07	$779.52
	FAMILY	$329.92	$1,682.76	$2,474.64
BlueCross/ BlueShield PPO	EMPLOYEE	$111.72	$569.77	$837.90
	FAMILY	$354.64	$1,808.79	$2,659.98
BlueCross/BlueShield Saver's Choice	EMPLOYEE	$86.80	$442.80	$651.18
	FAMILY	$275.62	$1,405.70	$2,067.21

DENTAL				
Plan Choices	Coverage	Monthly COBRA Rate 20%	Monthly COBRA Rate 102%	Monthly COBRA Rate 150%- SSDI
Cigna Dental HMO	EMPLOYEE	$0.00	$27.87	$40.98
	FAMILY	$18.82	$76.81	$112.95
Cigna Dental PPO	EMPLOYEE	$0.00	$51.39	$75.57
	FAMILY	$34.72	$141.65	$208.31
Cigna Dental PPO Plus	EMPLOYEE	$5.19	$56.68	$83.36
	FAMILY	$49.02	$156.23	$229.76

VISION				
Plan Choices	Coverage	Monthly COBRA Rate Employee	Monthly COBRA Rate 102%	Monthly COBRA Rate 150%
Vision Plan 1	SINGLE	$11.40	$11.63	$17.10
	FAMILY	$26.86	$27.40	$40.29

City of Phoenix

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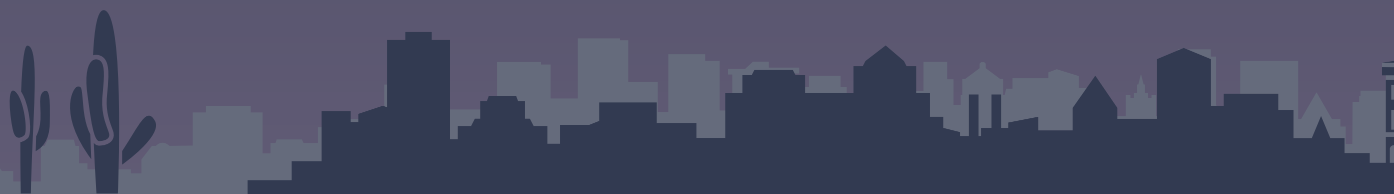


Welcome to Your 2019 Benefits

As a City of Phoenix employee, you work hard to contribute to the City's success. We know your benefits are important to you, and we work hard to ensure that we offer a competitive, flexible, and affordable benefits package that meets your needs – and those of your family. Our benefits program is broad and comprehensive, including health care, life insurance, disability insurance, and much more. You can select from a variety of plans and coverage levels to create a benefits program that's exactly right for your personal situation.

This *2019 Employee Benefits Guide* includes important information and updates about your City of Phoenix employee benefits. Things can change from one year to the next, and this guide is the primary way we communicate changes to you.

Please review this guide:

- Before making your new hire benefit decisions and elections;
- During Open Enrollment – to see the next year's plan options and features before deciding whether to make changes or let your current elections roll forward; and
- When a life event occurs – such as marriage, birth, adoption, divorce, legal guardianship, or loss of other group coverage – that may impact your benefits coverage.

If you have any questions about your benefit choices or how to enroll, please call Alicia Eshenbaugh at (602) 261-8724, or send an email to **alicia.eshenbaugh@phoenix.gov**. City offices are open Monday through Friday, from 8 a.m. to 5 p.m.

This guide provides highlights of the City of Phoenix employee benefit plans, effective January 1, 2019. Please keep in mind that summary plan descriptions, coverage certificates, policies, and contracts prevail when questions of coverage arise.

Benefit plans, premiums, networks, and out-of-pocket costs can change from one year to the next. This guide is how the City notifies you about upcoming changes that can impact you and your family.

2019 Benefits Open Enrollment

Benefits Open Enrollment for 2019 runs from October 22 to November 9, 2018. Be sure to review your benefits and make any changes by completing the form provided by ASI COBRA. The form must be completed and postmarked by the November 9 deadline. Visit **phxbenefits.com** for more information.

What's New for 2019

Great News About 2019 Premium Rates

The City is pleased to announce that premium rates *will not increase* in 2019 for employee medical plans and dental plans!

Vendor and Plan Changes

Your City of Phoenix employee benefits don't stay the same from year to year – sometimes vendors change. The City's contracts with several benefits vendors expire at the end of 2018, which required us to undergo a formal and transparent procurement process earlier this year. A selection committee, which included employee representatives, reviewed the proposals and interviewed vendors to identify the best fit for each need.

The Health Care Trust Board, the City Manager's Office, and the City Council approved all recommendations before they were finalized. These procurement processes resulted in several new benefits vendors for 2019.

Here is a summary of the vendor and plan changes effective January 1, 2019:

» **The Banner|Aetna HMO plan is replacing the Cigna HMO and Blue Cross Blue Shield HMO plans.** If you're currently enrolled in an HMO plan today and don't choose another medical plan during Open Enrollment, you and any covered dependents will be automatically enrolled in the Banner|Aetna HMO for 2019. For more information, see page 9.

» **We are working on expanding our chiropractic network** to improve your access to quality care. See page 16 for more information.

» **EnvisionRx will be the new pharmacy benefits provider.** The formulary, or prescription drug list, is very comparable to the drug list used today. Your co-pays and costs for each drug tier will also remain the same. For details, see page 19.

» **There will be one Avesis vision plan option in 2019 instead of two**, as the "Glasses AND Contacts" plan will no longer be offered. If you're currently enrolled in this plan and don't make a change during Open Enrollment, you and any covered dependents will automatically be enrolled in the "Glasses OR Contacts" plan for 2019. See pages 26 – 27 for details about your vision plan options.

Who's Eligible for Coverage

You may enroll your eligible dependents under the City's medical, pharmacy, dental, vision, and life insurance benefits. During enrollment, you will be asked to certify that your dependents meet the requirements for coverage as eligible dependents.

Eligible Dependents

Eligible dependents include:

- Your legally married spouse, which includes a legally married same-sex spouse.
- Your qualified domestic partner (approval process required – see page 6).
- Your children up to age 26, including:
  - Biological children.
  - Your adopted children or children placed with you for adoption.
  - Your stepchildren while you are legally married to their parent. When a legal separation or divorce occurs, stepchildren are no longer eligible.
  - Your qualified domestic partner's biological children while the qualified domestic partnership is approved and intact.
  - Children living with you for whom you have legal custody or court-approved guardianship may be covered until the custody or guardianship expires.
  - Children enrolled in the City's medical and/or dental plan the day before they turn 26, are primarily supported by you, and are incapable of self-sustaining employment due to permanent disability may be eligible for coverage beyond age 26. An application and medical information must be provided to Banner|Aetna or Blue Cross Blue Shield within 31 days of the child turning age 26. Contact the City's onsite Banner|Aetna or Blue Cross Blue Shield representative at (602) 262-4777 for information.

The City of Phoenix Benefits Office may request documentation to establish a dependent's eligibility for benefits at any time. Failure to provide adequate or timely documentation will prevent or delay enrollment, or result in the removal of dependents from coverage.

The employee is responsible to repay the City for claims incurred by ineligible dependents. Repayment is via payroll deduction.

Note: Having ineligible dependents enrolled in your City benefits coverage may result in disciplinary action, up to and including termination.

Enrollment Policies

Are you a City employee married to another City employee?

Social Security Numbers

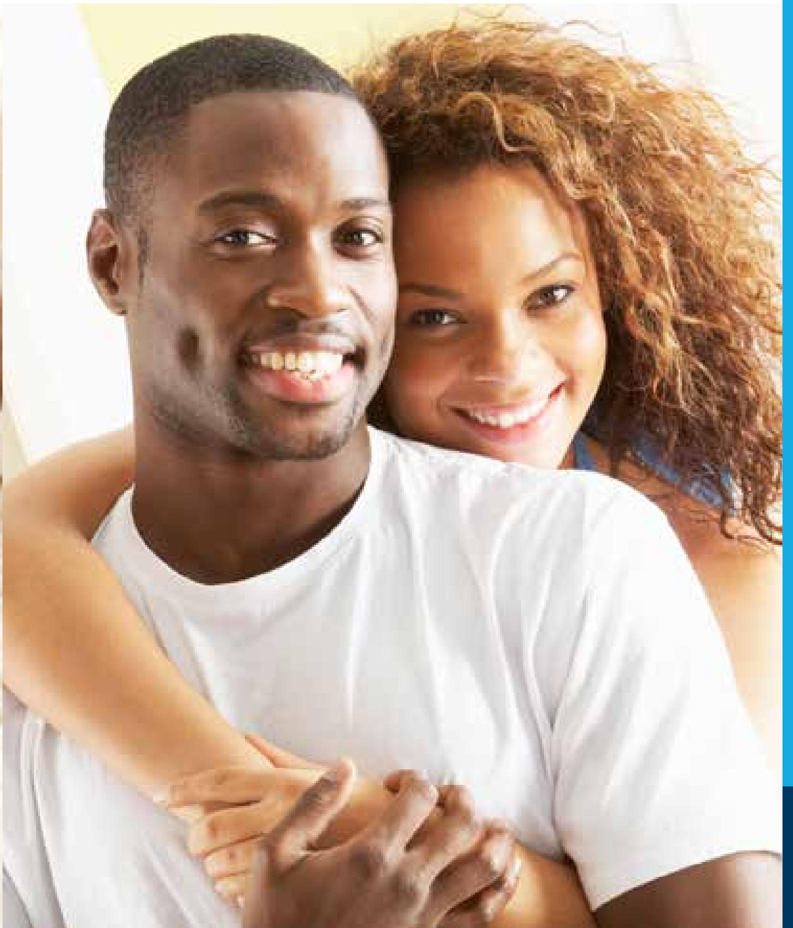
- SSNs must be provided to the Benefits Office in order to cover eligible dependents.

Medical Child Support Orders

- An employee cannot terminate coverage for a child whose enrollment is court-ordered.

Newborns

- A newborn will not automatically be added to your coverage. You must take action to add a new child using eCHRIS Self-Service within 31 days. Contact the City's Benefits Office for assistance.



Medical and Pharmacy Benefits

The City's medical and pharmacy coverage provides you and your family with the coverage you need for regular preventive care to stay healthy, as well as for when you need to obtain care in the event of illness or injury.

Choose the Plan That's Right for You

You can choose one of the three City medical plans:

- **Banner|Aetna HMO Plan.** The Banner|Aetna HMO is an innovative partnership between a large, successful health care provider and an established health plan administrator. The plan offers a large local and national network, which includes Phoenix Children's Hospital, Mayo Clinic, Dignity Health, Honor Health, and others – in addition to Banner providers and facilities.
- **Blue Cross Blue Shield PPO Plan.** The Blue Cross Blue Shield PPO provides a large national network, plus out-of-network coverage at a higher out-of-pocket cost.
- **Blue Cross Blue Shield Savers Choice Plan with Health Savings Account (HSA).** The Savers Choice Plan offers a generous HSA contribution from the City, premium savings, and the same large national network you'd find with the PPO.

Each medical plan offers:

- **Comprehensive, affordable coverage** for a wide range of health care services.
- **Large, national provider networks.**
- **Free in-network preventive care**, with services such as annual physicals, recommended immunizations, and routine cancer screenings covered at 100%.
- **Pharmacy benefits**, with prescription drug coverage provided by EnvisionRx.
- **Annual out-of-pocket maximums** that limit the amount you'll pay each year.

The key difference between the plans is the amount of money – your premium – that you'll pay each pay period. The plans may also differ in the following features:

- **Annual deductible** – the amount you pay each year for eligible medical or pharmacy charges before the plan begins to pay.
- **Out-of-pocket maximums** – the most you will pay each year for eligible in-network services, including prescriptions.
- **Co-pays and coinsurance** – the money you pay toward the cost of covered services.

Don't have a Primary Care Physician (PCP)? You should. Here's why.

- **Better health.** Getting the right health screenings each year can reduce your risk for many serious conditions. Preventive care is free, so there's no excuse to skip it.
- **A healthier wallet.** Having a doctor you can call helps you avoid costly trips to the emergency room, and to decide when you really need to see a specialist.
- **Peace of mind.** Advice from someone you trust ... it means a lot when you're healthy, but it's even more important when you're sick. Your PCP gets to know you and your health history and can help coordinate any care you need.

Banner | Aetna HMO

Beginning January 1, 2019, the City will offer the Banner|Aetna HMO as the medical HMO plan option. The City conducted a procurement process for medical plan services in early 2018, which resulted in the selection of Banner|Aetna for the HMO plan.

Something special happens when a successful health care organization becomes an equal partner with an established insurance company:

- Medical providers have higher levels of satisfaction and trust.
- Administrative efficiencies are realized.
- Everyone cooperates toward a common goal – better health care.

Lower co-pays in 2019 for many services!

The City is excited to offer this innovative health care approach to our employees and families.

With the HMO plan, you can choose to save money by seeing a Primary Care Physician (PCP) who can coordinate care with any specialists. Note that services received outside the network are not covered except for emergency services.

The Banner|Aetna HMO Network

The HMO plan gives you access to a Broad Network that includes a national network of providers, and a local Performance Network that includes:

- 1,891 primary care physicians.
- 8,632 specialists.
- Access to more than 120 urgent care centers.
- 23 hospitals.
- 12 Banner Health Centers offering primary and specialty care under one roof.
- Phoenix Children's Hospital, through a customized arrangement for the City.

You can see providers from both networks seamlessly, but your out-of-pocket costs are lower when you use a provider in the Performance Network.

The local Banner|Aetna network providers are a 99% match to the providers available through the Cigna and BCBS HMO plans you know today. However, Cigna Medical Group Clinics are not included in the Banner|Aetna networks.

Find a Banner|Aetna Provider

Search for in-network Banner|Aetna HMO providers here:

- Visit the www.aetna.com/cityofphoenix website.
- Click on "Find a Doctor" and follow the prompts.
- Enter your location and search parameters.
- You can search for HMO providers within the Performance Network (lower co-pays) or the Broad Network (slightly higher co-pays).

  You'll see a teal-colored box with "Maximum Savings" for providers in the Performance Network, and a dark red box with "Standard Savings" for providers in the Broad Network.

HMO Coverage

- National Broad or local Performance network.
- No calendar-year deductible.
- Zero coinsurance.
- Same or lower co-pays than current HMO plans.

Additional Resources

The Banner|Aetna HMO plan also provides additional resources to enhance your experience as a member, including:

» **Combined Online Portal.** Visit Banner|Aetna's combined online portal at www.aetna.com/cityofphoenix to save the time and hassle of figuring out where to go for information. The portal links your insurance information with your health care information, and allows you to:
  - Message your doctors directly.
  - Request prescription refills.
  - Schedule an appointment.
  - View lab and test results.

» **Easier and Increased Access to Care.** Banner|Aetna's neighborhood care model and multi-disciplinary care teams allow your doctor to lead and direct your care without barriers and administrative hassles. You'll have easy access to doctors, specialists, pharmacists, and other providers with extended knowledge of local resources to aid every aspect of your life.

» **Onsite Banner|Aetna Representative.** We're pleased to introduce Devon Moore as the City's onsite Banner|Aetna representative. Her office is on the 7th floor of the City's Calvin C. Goode Building. Recently, Devon represented Banner|Aetna as an onsite representative at the Arizona Department of Administration for State of Arizona employees. She can be reached at devon.moore@phoenix.gov or (602) 495-5724.

How the Banner|Aetna HMO Works

First, you pay the plan premium from your paycheck to have coverage.		
Co-pay	**Deductible**	**Out-of-Pocket Maximum**
You **pay a portion of the cost of service** at the time of service for in-network medical care and prescriptions.	This plan has **no annual deductible** for in-network care. The **plan pays 100% of covered costs** after you pay your co-pay.	You're protected by an annual limit on costs — the **plan pays 100%** of any further covered expenses for the rest of the year.

Keep in mind: You pay nothing for **in-network preventive care**—it's covered in full. However, services received outside the large Banner|Aetna network are not covered.

Blue Cross Blue Shield PPO

This PPO type of medical plan lets you visit the doctor of your choice. Although you may see a provider who doesn't participate in the plan's network, in most cases your benefits are greater (and your out-of-pocket expenses smaller) when you see a network provider. You are not required to select a Primary Care Physician (PCP) under this option, but you will save additional money when you do. Once you reach the deductible, you will pay coinsurance until the out-of-pocket maximum is met, then the plan will pay 100%.

The PPO Provider Network

The City's PPO coverage is provided through a large local and national network. There are almost 10,000 physicians in the local PPO network and more than 30 hospitals, including Mayo Clinic, Phoenix Children's Hospital, and St. Joseph's Hospital.

PPO Coverage

In-Network (a large, national network)

- $300 deductible, 20% coinsurance.
- Max. $900 per person, $2,700 per family.

Out-of-Network:

- $600 deductible, 20% coinsurance.
- Max. $1,500 per person, $4,500 per family.
- Preventive care and vision are not covered out-of-network.
- The out-of-network deductible and coinsurance are tracked separately from the in-network deductible and coinsurance.
- Balance billing applies.

Find a Blue Cross Blue Shield PPO Provider

- Visit the www.azblue.com website.
- Click on "Find a Doctor/Rx."
- Click on the option that best describes you, and follow the prompts.

Deductibles Carry Over

When you don't meet your deductible during the year, your expenses applied toward the deductible in the fourth quarter carry forward to the following calendar year's deductible.

About Co-pays

Co-pays are used for prescriptions, vision exams, and pre-natal visits. A $10 co-pay is also available for Primary Care Physician (PCP) office visits when you use a Patient-Centered Medical Home (PCMH) physician. Co-pays do not count toward the deductible or coinsurance.

How the Blue Cross Blue Shield PPO Works

First, you pay the plan premium from your paycheck to have coverage.

Co-pay	Deductible	Coinsurance	Out-of-Pocket Maximum
You **pay a small fee** at the time of service for a few services, as well as prescriptions.	For most services you **pay 100% of the contracted costs** until you meet the annual **per-person deductible**.	After meeting the deductible, **you pay 20% of the contracted costs until you reach $900 out-of-pocket** (per person), including the deductible.	When you've reached $900 per person or $2,700 per family of 3 or more, your covered medical services are provided **at no cost to you**.

Keep in mind: You pay nothing for **in-network preventive care**—it's covered in full.

BCBS Savers Choice Plan with HSA

This type of High Deductible Health Plan (HDHP) gives you the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs. Once your deductible has been met, you will continue to pay a prescription co-pay until your out-of-pocket maximum is met, and then the plan pays 100%.

The Blue Cross Blue Shield Savers Choice Plan is the most practical plan for those who expect to incur more than $1,500 (single) or $3,000 (family) in medical costs during the calendar year, or for those who expect to incur very little medical cost. This plan offers the lowest premiums and a tax-free Health Savings Account (HSA) (see page 13 for more information about the HSA). The City will contribute one-half of your annual deductible to your HSA – that's $750 for employee-only coverage and $1,500 for family coverage. The money in your HSA can be carried forward from year to year and is always yours to keep.

The Savers Choice Provider Network

The Savers Choice plan coverage is provided through the same large, local and national network of providers as the PPO plan. There are almost 10,000 physicians in the local network and more than 30 hospitals, including Mayo Clinic, Phoenix Children's Hospital, and St. Joseph's Hospital.

Savers Choice Plan Coverage

» National network (same as PPO).

» Deductible of $1,500 or $3,000.

» Zero coinsurance.

» Preventive drug list that bypasses the deductible.

» Lowest premium cost.

Savers Choice Plan Members Save with Co-pays!

The plan includes a new preventive drug list, which means generic medications for a number of chronic health conditions are only a $5 co-pay, bypassing the deductible. That's good news!

Costs are based on discounted and contracted rates pre-determined with pharmacies and contracted providers. Use your free HSA debit card to pay for these expenses. After the deductible is fulfilled, your only out-of-pocket costs are prescription drug co-pays of $5, $30, or $50. The maximum you will pay for these co-pays is $1,500 for single coverage and $3,000 for family coverage.

Find a Blue Cross Blue Shield Provider

» Visit the www.azblue.com website.

» Click on "Find a Doctor/Rx."

» Click on the option that best describes you, and follow the prompts.

These Costs Count Toward Your Deductible

» Covered pharmacy costs.

» Covered vision costs.

» Covered medical care.

Choosing Your Medical Plan

	HMO	PPO	Savers Choice Plan
Do I need a referral from my PCP to see a specialist?	No	No	No
Am I required to use the plan's network of physicians, hospitals, etc.?	Yes, except in the event of an emergency.	No, but out-of-network providers will cost you more than in-network.	Yes, except in the event of an emergency.
How large is the plan's network?	National – Broad Network Local – Performance Network	National Maricopa County: 30+ hospitals and approximately 9,800 providers	National Maricopa County: 30+ hospitals and approximately 9,800 providers
Is there out of area coverage, other than for emergencies?	Yes, nationally	Yes, nationally	Yes, nationally
Access to Mayo and Phoenix Children's Hospital?	Yes	Yes	Yes
Is there an annual deductible?	No	Yes	Yes
Is there coinsurance?	No	Yes	No
Are there co-pays?	Yes	For a few services.	Only for prescriptions after the deductible is fulfilled.
What is the most I will pay out of pocket in medical co-pays, deductible, and/or coinsurance during the calendar year?	$6,600 for single coverage, $13,200 for family coverage.	$900 per person, capped at $2,700 per family of 3 or more.	$1,500 for single coverage, $3,000 for family coverage.
Will I be enrolled in a Health Savings Account with this plan?	No	No	No, but you have the option to enroll in a Health Savings Account.
What makes each plan distinctive?	The HMO plan has co-pays only.	The PPO is the only plan with out- of-network coverage.	This is the only plan with access to a Health Savings Account.

Medical Benefits at a Glance

	HMO	PPO		Savers Choice Health Plan
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Networks	Banner|Aetna HMO Broad or Performance	BCBS PPO	Not applicable	BCBS PPO
Local or National Network?	National	National	Not applicable	National
Out-of-Network Coverage?	For emergency services	For emergency services	Yes	For emergency services
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible	None	$300 per person per year, capped at $900 per family of 3 or more.	$600 per person per year, capped at $1,800 per family of 3 or more.	$1,500 for single $3,000 for all covered family members combined
Coinsurance	None	20%	20%	None
Calendar Year Out-of-Pocket Maximum for Medical Services	Medical: Performance Network Single: $3,000 Family: $6,000 Broad Network Single: $5,100 Family: $10,200 Pharmacy: Single: $1,500 Family: $3,000	Medical: $900 per covered member, capped at $2,700 per family of 3 or more. Pharmacy: $1,500 per covered member, capped at $3,000 per family of 2 or more.	$1,500 per covered member to a maximum of $4,500 per family of 3 or more.	$3,000 for single $6,000 for family Pharmacy co-pays apply to this amount after the deductible is fulfilled.
What's Not Subject to Deductible and Coinsurance?	Not applicable	Designated PCP visits, preventive care, pharmacy, pre-natal office visits, and vision.	Everything covered out-of-network is subject to deductible and coinsurance.	Preventive care
Health Savings Account?	No	No	No	Yes

Enhanced Chiropractic Network

In previous years, the City provided chiropractic coverage exclusively through the American Specialty Health (ASH) network. In 2019, we'll continue to offer benefits through ASH, but will also be working to expand our network of chiropractors over the course of the year.

If you have a chiropractor to nominate for any of the City's networks, please send his or her information to: benefits.questions@phoenix.gov

	HMO	PPO		Savers Choice Health Plan
	In-Network Only	**In-Network**	**Out-of-Network**	**In-Network Only**
Prenatal Office Visits	$30 for the first visit, $0 thereafter	$30 for the first visit, $0 thereafter	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is the member's responsibility to pay.	Plan pays 100% of the contracted rate after the calendar year deductible is met.
Office Visit, Primary Care	Performance Network PCP: $10 Broad Network PCP: $30	You pay 20% of the contracted rate after the deductible is met. $0 after the calendar year out- of-pocket maximum is met.		
Office Visit, Specialist	Performance Network: $30 Broad Network: $45			
Office Visit, Mental Health	Performance Network: $10 Broad Network: $10			
Outpatient Procedure	$100			
Inpatient Hospitalization	Performance Network: $100/admit, max $300/yr Broad Network: $150/ admit, max $450/yr			
Lab and X-rays	Performance Network: Covered 100% Broad Network: $50			
Urgent Care Facility	$50			
Hospital Emergency Room	$150			
Physical Therapy, Occupational Therapy	Plan pays 100% with no deductible or co-pays			
Chiropractic 30 visits max per plan year	Performance Network: $30 Broad Network: $45			
Hearing Aids Max. 1 every other year per ear	90% coverage			
Eye Exam with Optometrist Every 12 months	$25	$25	Not Covered	
Generic Drugs	$5	$5		Members pay 100% of prescription cost until deductible is met. After that the same drug co-pays used for HMO and PPO apply.
Brand-name Drugs	$30	$30		
Non-formulary Drugs	$50	$50		
Specialty Drugs	$50	$50		
Mandatory Mail Order for Maintenance Medication	Yes, with certain retail pharmacies included (CVS, Target, and Fry's).		Not applicable	Yes, with certain retail pharmacies included (CVS, Target, and Fry's).

Adult Preventive Care Summary

The following services are provided at no cost to you as appropriate for age and gender, and as recommended by your provider.

	Adult women age 18 – 49	Adult men age 18 – 49	Adult women age 50 and up	Adult men age 50 and up
Annual wellness exam Covered as often as the physician deems necessary.	Yes	Yes	Yes	Yes
Annual well woman exam	Yes		Yes	
AAA screening Abdominal aortic aneurysm				Yes
Chicken pox immunization	Yes, if no proof of immunity	Yes, if no proof of immunity	Yes, if no proof of immunity	Yes, if no proof of immunity
Colorectal cancer screening			Yes	Yes
Contraception	Yes		Yes	
Diabetes Type 2 screening Blood glucose	Yes	Yes	Yes	Yes
Domestic violence screening	Yes	Yes	Yes	Yes
Flu immunization	Yes	Yes	Yes	Yes
Lipid screening Blood cholesterol	Yes, over age 40 – 45	Yes, over age 40 – 45	Yes	Yes
Mammogram Breast cancer screening	Yes, over age 35 – 40		Yes	
MMR immunization	Yes, if no proof of immunity	Yes, if no proof of immunity	Yes, if at risk	Yes, if at risk
Osteoporosis screening Bone density			Yes	Yes
Pap smear Cervical cancer screening	Yes		Yes	
Pneumonia immunization			Yes	Yes
STD screenings	Yes	Yes	Yes	Yes
Shingles immunization			Yes	Yes
Tetanus, diphtheria, whooping cough immunization	Yes, every 10 yrs.	Yes, every 10 yrs.	Yes, every 10 yrs.	Yes, every 10 yrs.

Pharmacy Benefits

In 2019, EnvisionRx will replace Cigna Pharmacy for all three medical plans — the HMO, PPO, and Savers Choice Plans.

EnvisionRx offers comprehensive pharmacy benefits, including home delivery and specialty drug services. **Please note that beginning January 1, 2019, all refill prescriptions for mail-order and specialty drugs will be automatically transferred from Cigna to EnvisionRx.**

Pharmacy co-pays are not changing in 2019.

With EnvisionRx, you have access to more than 67,000 retail pharmacies nationwide for your 30-day prescriptions.

Remember that if you enroll in the Savers Choice Plan, you must meet an annual deductible before your co-pay-based pharmacy benefits begin. Both your medical expenses through the Savers Choice Plan and your pharmacy expenses (at a discounted cost through EnvisionRx) count toward the Savers Choice Plan annual deductible.

Maintenance Medication Requirements

For 90-day prescriptions, the City continues to require you to fill maintenance medications using mail order or specific retail locations. **Effective January 1, 2019, the retail locations available for 90-day fills are CVS, Target, and Fry's.**

Remember — you save by paying only two co-pays for 90 days of medication.

You can set up mail order prescriptions by calling EnvisionRx directly or visiting their website for City of Phoenix employees.

Drug Tiers

The cost of your prescription drugs under the City's medical plans depends on the tier of the medication:

- **Generic drugs** contain the same active ingredients as their brand-name equivalents and meet the same federal standards for safety, but typically cost significantly less.
- **Formulary drugs** are brand-name medications that are favored by a prescription plan based on drug effectiveness and cost.
- **Nonformulary drugs** are brand-name medications that are not on a prescription plan's favored list (or formulary) based on drug effectiveness and cost. They may still be covered, but may require prior authorization and cost more.

EnvisionRx = New Provider

Visit EnvisionRx's City of Phoenix employee website to review your pharmacy benefit options, find a network pharmacy, and check co-pay and drug pricing.

Employee Website: phxrx.envisionrx.com

Preview code: PHXRX. No registration is necessary.

Phone: (833) 803-4402 – 24 hours a day, 7 days a week

Behavioral Health Benefits

Mental health is as important to our well-being as physical health. Your medical plan covers office visits with licensed psychiatrists, psychologists, and counselors, as well as outpatient and inpatient programs for certain needs.

Aetna|Banner HMO Plan

Local behavioral health professionals and facilities are available through the HMO's Broad or Performance provider networks. The office visit co-pay is $10 whether or not you see a Performance Network provider or a Broad Network provider. Pre-certification is required for non-emergency inpatient covered services.

Blue Cross Blue Shield PPO Plan

Behavioral health services are available through a national Blue Cross Blue Shield network and from licensed and accredited out-of-network providers. The City has worked to broaden and strengthen this network of providers and facilities, and we will continue to do so. Pre-certification is required for non-emergency inpatient behavioral and mental health admissions. The PPO deductible and coinsurance apply.

Blue Cross Blue Shield Savers Choice Plan

Behavioral health services are available through a national Blue Cross Blue Shield network. There is no out-of-network coverage. Covered services and pre-certification requirements are the same as for the PPO. The Savers Choice deductible applies.

Exclusions

Exclusions for all plans include non-licensed facilities, group homes, halfway houses, assisted living, wilderness programs, non-emergency inpatient services at a non-approved facility, and residential treatment centers.

Dental Benefits

Our dental plans help you maintain good dental health through affordable options for preventive care, including regular checkups and other dental work. Premium contributions for dental will be deducted from your paycheck on a pre-tax basis. The plan you choose will determine your premium.

PPO Dental Plan

Two levels of benefits are available with the PPO dental plan, depending on whether your dentist is in or out of the PPO network. You have the flexibility to select the provider of your choice, but your level of coverage may vary based on the provider you see for services. Staying in-network and going to a contracted PPO provider will provide you with the highest level of benefits and the deepest discounts your plan offers.

- All services are covered at 80%.
- The annual $50 deductible does not apply to preventive services such as cleanings, exams, and x-rays.
- The maximum annual benefit per member is $2,000 per calendar year for general services and a $4,000 lifetime benefit for orthodontia.

PPO Plus Dental Plan

The PPO Buy-up Dental Plan mirrors the PPO Dental Plan with a national network of dentists and out-of-network coverage. For a small premium increase, additional coverage includes:

- The maximum annual benefit per member increases from $2,000 to $3,000 per member.
- Coverage for implants is added under major restorative benefits.

HMO Dental Plan

When you enroll in the HMO Dental plan, you must choose a primary dentist from the HMO network directory to manage your care. This network is smaller than the dental PPO network. Before you elect the Dental HMO, be sure that the plan's network includes the dentists of your choice. There is no deductible and no charge for preventive services. A Fee Schedule determines the amount you pay when dental services are required.

Cigna Dental

Phone: (800) 244-6224
Online: mycigna.com

Each covered family member will be assigned to a network dentist who can be changed by calling Cigna Dental at (800) 244-6224. When you contact Cigna Dental by the 20th of the month, your assigned dentist will be changed on the first of the next month.

Dental Benefits at a Glance

	HMO Dental	PPO Dental		PPO Plus Plan	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Dentists	Cigna Care Network	Cigna Core Network	Any licensed dentist	Cigna Core Network	Any licensed dentist
Deductible	None	$50 per calendar year, maximum $150 per family. Deductible does not apply to preventive services.		$50 per calendar year, maximum $150 per family. Deductible does not apply to preventive services.	
Cleanings, exams, x-rays	No charge	Plan pays 80% of covered charges	Plan pays 80% of Reasonable and Customary Charges	Plan pays 80% of covered charges	Plan pays 80% of Reasonable and Customary Charges
Extractions, fillings, crowns, dentures, bridges, root canals, oral surgery	See the HMO Dental Coverage and Fee Schedule				
Maximum annual benefit	No maximum for most covered services	Up to $2,000 per member per calendar year for covered services		Up to $3,000 per member per calendar year for covered services	
Lifetime orthodontia benefit	See the HMO Dental Coverage and Fee Schedule	$4,000 per person		$4,000 per person	
Implant benefit	None	None		Up to $3,000 per member per calendar year for covered services	

Cigna Dental Oral Health Integration Program

Added coverage is available with certain health conditions—contact your Cigna Dental Representative at linda.sawyer@cigna.com.

	Heart Disease	Stroke	Diabetes	Maternity	Chronic Kidney Disease	Organ Transplants	Head and Neck Cancer Radiation
Periodontal Treatment & Maintenance	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Periodontal Evaluation				Yes			
Oral Evaluation				Yes			
Emergency Palliative Treatment				Yes			
Topical Application of Fluoride or Fluoride Varnish					Yes	Yes	Yes
Sealants					Yes	Yes	Yes
Sealant Repair					Yes	Yes	Yes

Vision Benefits

Core Vision Plan

Our vision plan is Included with your medical plan at no additional cost to you. Although vision care services and supplies are covered in- and out-of-network, your benefits are generally greater when you use network providers. Your cost for 2019 reflects the family members you cover.

	Core Vision Coverage
Exam every 12 months	$25
Frames every 12 months	$30 credit
Single Vision Lenses every 12 mos.	$20 – $40 credit
Contacts	$75 credit
Gradient tint; polycarbonate lenses; solid tint; standard anti- reflective coating; standard progressive lenses; standard scratch resistant coating; ultraviolet coating	20% discount may apply
Vision Provider Network	Banner|Aetna HMO: Aetna Vision Network BCBS: Blue Cross Network
Pre-tax Payroll Deduction	None; already included with the City's medical coverage

Avesis Buy-Up Vision Plan

You have ONE coverage option, provided by Avesis: Glasses OR Contacts every 12 months.

Vision Care Service	In-Network Benefit	Out-of-Network Reimbursement
Eye Exam	$10 Co-pay	Up to $40
Materials		
Frame Allowance	$175 retail value Participating Walmart, Costco and Sam's Club: $88*	Up to $45
Single Vision Lenses	Covered in full	Up to $40
Bifocal Lenses	Covered in full	Up to $60
Trifocal, Lenticular Lenses	Covered in full	Up to $80
Standard Progressive Lenses	Brands: Shoreview, Shoreview Mini, Navigator, Navigator Short, and Super Noline.	Up to $60
Premium Progressive Lenses	Brands: Younger Image, Shamir Silver, Essilor, Smallfit, and Ideal. EyeFocal Select L2 Digital HD is offered only by independent providers.	Up to $60

Vision Care Service	In-Network Benefit	Out-of-Network Reimbursement
Polycarbonate Lenses	Covered in full	Up to $10
Standard Scratch Resistant Coating	Covered in full	Up to $5
Standard Tint	Covered in full	Up to $4
Standard Anti-Reflective Coating	Covered in full	Up to $24
Transitions	Covered in full	Up to $30
All other lens options	Discounted up to 20% off retail	N/A
Contact Lenses		
Elective	$175 allowance	Up to $175
Medically Necessary	Covered in full	Up to $250
Contact Lens Fit and Follow Up	Covered in full	N/A
Frequency		
Eye Examination	Once every 12 months	
Lenses, Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

**Please note that coverage is lower at these discount retailers. Don't assume you will have the lowest out-of-pocket cost at these locations.*

Finding a Provider

- Find a listing of providers at www.avesis.com
- Select PROVIDER SEARCH and enter a zip code and radius

Providers include: Nationwide Vision, Target Optical, Sears Optical, Visionworks, America's Best Contacts & Eyeglasses, Walmart, Sam's Club, Costco, JCPenney Optical, Eyeglass World, Pearle Vision, and many independent vision providers.

The Buy-Up Vision Plan and the Medical Plan Vision Benefits

The Avesis coverage and the core vision coverage do not "coordinate." In other words, you cannot apply both coverages to the same purchase for glasses or contacts. You can, however, use each coverage separately one time each year.

Avesis

Phone: (800) 828-9341 7:00 a.m. to 8:00 p.m. EST
Online: www.avesis.com

Flexrap

Flexrap is the City's Flexible Spending Account (FSA) program. Flexible Spending Accounts (FSAs) allow you to pay for eligible healthcare and daycare expenses using tax-free dollars. You can save up to 25%!

There are two types of FSAs:

» **Flexrap Healthcare Account** – Used to pay for services not covered by your medical, dental, or vision plan, such as co-pays, coinsurance, deductibles, prescription expenses, lab exams and tests, contact lenses, and eyeglasses.

» **Flexrap Daycare Account** – Used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Flexrap Healthcare FSA to pay for Daycare expenses.

It's easy to use these accounts:

First, you contribute to the account(s) with pre-tax dollars deducted from your paycheck. That means no taxes (federal, state, or Social Security) will be withheld from any of those dollars.

The annual deadline for submitting 2018 claims is March 31, 2019.

When you enroll in the Flexrap Healthcare Account, you can request an ASI debit card pre-loaded with your annual Flexrap healthcare contribution. You can be reimbursed using the ASIFlex online portal, the mobile phone app, or by submitting claims via fax or mail. When you set up direct deposit, your reimbursement will appear in your account within 3 business days of ASIFlex receiving your claim and documentation.

Important: There is a "use it or lose it" rule imposed by the IRS. In other words, if you do not spend all the money in your FSA by the deadline, any unused dollars in your account(s) after the deadline will be forfeited. **THERE IS NO ROLLOVER OF FLEXRAP FUNDS.**

How the Flexrap Healthcare Account Works	How the Flexrap Daycare Account Works
Contribute up to $2,650 per year, pre-tax. Note that this the 2018 IRS limit; the 2019 limit was not available at the time of this printing.	Contribute up to $5,000 per year, pre-tax, or $2,500 if married and filing separate tax returns.
Receive a debit card to pay for eligible medical expenses (funds must be available in your account).	You must submit claims and be reimbursed if you enroll in this FSA; no debit cards are provided.
Eligible expenses include medical co-pays, coinsurance, deductibles, eyeglasses, and over-the-counter medications prescribed by your doctor.	Can only be used to pay for eligible dependent care expenses including day care, after-school programs, and elder care programs.
Submit claims up to March 31 of the following year for expenses from January 1 to December 31.	Submit claims up to March 31 of the following year for expenses from January 1 to December 31.
If you do not spend all the money in this FSA by March 31, unused dollars will be forfeited per IRS regulations for pre-tax contributions.	If you do not spend all the money in this FSA by March 31, unused dollars will be forfeited per IRS regulations for pre-tax contributions.

Note: If you are enrolled in the Savers Choice Plan, IRS Code requires that your enrollment in Flexrap is limited to reimbursement for dental and vision expenses only. This is known as a Limited Purpose FSA. Your Health Savings Account (HSA) can be used for medical and pharmacy costs.

What You Need to Know

- Flexrap enrollment does not automatically carry over from one year to the next.
- Eligible expenses must be incurred in the calendar year for which you are enrolled.
- When you have a qualifying event such as marriage, birth, adoption, divorce, or a new day care provider, you can make a correlating change to your Flexrap amount when you contact the Benefits Office within 31 days of the event.

You cannot transfer money between the Healthcare Account and the Daycare Account. Please be sure you enroll for the correct Flexrap account.

ASIFlex

Phone: (800) 659-3035
Email: asi@asiflex.com
Online: www.asiflex.com

New to ASIFlex? Look for a welcome letter in the mail in December. It will provide you with a temporary PIN and instructions for signing in to the ASIFlex online portal. Use the portal to look up your balance, claims, claim status, and to file a claim. Visit my.asiflex.com.

Expense Reimbursement

Find an alphabetical list of eligible expenses at asiflex.com/eligible_expenses.html. Submit your expenses for reimbursement online, by fax, by mail, or via the ASIFlex mobile app. Set up direct deposit with ASIFlex to have your reimbursement automatically deposited. A check will be mailed if direct deposit is not established.

Manage Your Flexrap Accounts

Find Account Information Online

https://my.asiflex.com

Direct Deposit

https://webdocs.asiflex.com/D_D_Forms/ directdepositform.pdf

Claim Forms

http://www.asiflex.com/ClaimForms (choose General FSA Claim Form)

Note: You can submit claims without using a claim form when you submit online or via the mobile app.

Mobile App

Download the ASIFlex mobile app to look up information about your Flexrap account and submit claims. No claim form needed, just fill out some information, take a picture of your documentation, and submit. Search in your app store for ASIFlex.

Making Changes Mid-Year

During the year, you cannot make changes to your medical, dental, vision, and Flexrap Accounts unless you have a Qualified Life Event. If you do not contact Human Resources within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

Life Event	Enrollment Change	Documentation
Marriage **Qualified Domestic Partnership (QDP)**	Add new spouse	Legal marriage certificate
	Add partner	Qualified Domestic Partner (QDP) packet must be completed, turned in to the Benefits Office, and approved
	Add new stepchild	Legal marriage certificate or completed and approved QDP packet and the child's birth certificate
	Waive employee's coverage because employee is enrolling in coverage provided by the new spouse or QDP	Proof of enrollment in other group coverage
Divorce, Legal Separation, Dissolution of Qualified Domestic Partnership	Remove spouse or QDP and stepchildren from coverage	Divorce decree, legal separation documents, or QDP termination form
Birth of a Child	Add child to coverage	Birth certificate
Adoption of a Child or a Child Placed for Adoption	Add child to coverage	Legal adoption paperwork
Legal Guardianship or Custody of a Child	Add child to coverage	Court decree
Court-Ordered Coverage of a Child	Add child to coverage	Medical Child Support Order
Employee, Spouse, QDP, or Child Gains Other Coverage	Remove from coverage	Proof of other coverage with effective date
Moving Out of a Plan's Service Area	Current medical and/or dental plan does not provide non-emergency in the area	Proof of child, spouse, or QDP residing outside the current service area
Loss of Other Group Coverage	Employee and/or spouse, QDP, children lose other group coverage and wish to be added to the City's coverage	Legal marriage license, birth certificates, proof of loss of coverage with effective date

Who Sets the Medical Premiums?

The City began self-funding employee and retiree medical and pharmacy coverage almost 14 years ago to reduce the increasing costs of group medical coverage. Since that time, the City has set the annual premium rates based on claims history and projected medical expenses while maintaining an adequate reserve level in the trust that pays our claims.

The Health Care Benefits Trust holds the premium payments made by the City, employees, and retirees. Medical and pharmacy claim payments are made from this trust, as well as other necessary expenses such as leasing provider networks, claims adjudication, the appeals process, the drug formulary, stop loss coverage, and health care reform expenses. Self-funding has resulted in about 98% of every premium dollar going directly to claims expense.

Banner|Aetna and Blue Cross Blue Shield (BCBS) have been selected in competitive bidding processes to supply the networks we use for doctors, hospitals, labs, and other medical services. Each network provider has a contract in place with Banner|Aetna and/or Blue Cross Blue Shield. Each contract determines how much is paid for services. Provider contracts are negotiated regularly and subject to change. Providers may apply to join a network at any time and may choose to leave a network when their contract expires. The City does not control the contracts with providers or the decisions made by providers to join or leave a network.

The Health Care Task Force

The Health Care Task Force provides input on medical premium rates, co-pays, plan designs, and wellness programs. The task force is comprised of one representative from each bargaining unit and employee association, one representative from middle managers, one from executives, and one retiree representative.

The Health Care Benefits Trust Board

The Health Care Benefits Trust Board is charged with financial oversight for the trust that holds premium payments from employees, retirees, and the City. The Board is comprised of four members from the community with relevant benefits and/or financial background and one member representing COPCU (City of Phoenix Coalition of Unions).

The City's Contribution to Our Medical Premium

The City pays 80% of eligible full-time employee medical premiums, whether enrolled in single or family coverage.

Legal Notices

COBRA: 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 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' 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;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice to the City of Phoenix Benefits Office at 602-262-4777 or **benefits.questions@phoenix.gov**.

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 or qualified domestic partners, 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. Notify the City of Phoenix Benefits Office at 602-262-4777 or **benefits.questions@phoenix.gov**.

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, Medicaid 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**.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under 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 City of Phoenix know about any changes in the addresses of family members. Employee addresses should be maintained using eCHRIS Self-Service. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

City of Phoenix
Human Resources Department Benefits Office
Attention: Benefits Supervisor
251 W. Washington Street
Phoenix AZ 85003. 602-262-4777
benefits.questions@phoenix.gov.

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

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, the City of Phoenix Medical Plans provide(s) coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

YOUR SPECIAL ENROLLMENT RIGHTS

To ensure individuals have access to health care coverage, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Under the special enrollment provisions of HIPAA, you may be eligible to enroll in a City medical plan during the Plan Year, even if you previously declined coverage. This right extends to you and all eligible family members.

You will be eligible to enroll yourself (and any eligible dependents) in a City medical plan if:

- Your or your dependents' COBRA coverage under another plan ends involuntarily;
- You or your dependents have lost coverage under another plan because:
  - Employer contributions to the plan stopped (this will apply even if the covered individual continues receiving coverage under the prior plan by paying the amount previously paid by the employer)
  - The plan was terminated, or
  - There was a loss of eligibility due to divorce, legal separation, death, termination of employment, a reduction in hours to part-time status that affected benefits eligibility, the covered individual no longer lives or works in an HMO service area and no other benefit option is available, or the plan no longer offers benefits to a class of individuals that includes the previously covered individual.

- As a covered employee, a court has ordered you to provide coverage for a dependent;
- You or your dependent child loses eligibility for a state-sponsored Children's Health Insurance Plan or Medicaid coverage (you must notify the Human Resources Department within 60 days of the loss of eligibility); or,
- You or your dependent child gains eligibility for premium assistance subsidy under a state-sponsored Children's Health Insurance Plan or Medicaid (you must notify the Human Resources Department within 60 days of determination of subsidy eligibility).

In addition, if you gain a new dependent during the year (through birth, legal adoption or placement for adoption, or marriage), you may enroll that dependent, as well as yourself and any other eligible dependents, in your medical plan — again, even if you previously declined medical coverage.

This special enrollment right:

- Will be extended to you only if you notify the Human Resources Department **within 31 days of the event unless stated otherwise above;** and,
- Applies to medical coverage only. If you declined any other coverages, you must either wait until Open Enrollment to elect such coverage, or until you experience a qualifying change in status that enables you to change your benefit elections, in which case you may only make certain changes. For more details, see your benefit booklet.

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, 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).

To see if any other states have added a premium assistance program since July 31, 2018, 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

NOTICE OF PRIVACY PRACTICES

This notice describes how health plan medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes conditions on how a group health plan may use and disclose your individual health information, referred to here as "protected health information." It also gives you certain rights with respect to that information. This notice describes the privacy practices of the following health plans:

THE CITY OF PHOENIX EMPLOYEE MEDICAL, DENTAL, AND PRESCRIPTION DRUG PLANS

The plans covered by this notice may share health information with each other to carry out Treatment, Payment, or Health Care Operations, as described below. These plans are collectively referred to as "the Plan" in this notice, unless specified otherwise.

It is important to note that HIPAA's privacy rules only apply to health plans. Different policies may apply to other City of Phoenix sponsored programs, such as life insurance and disability.

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of your protected health information and to inform you about:

- The Plan's practices regarding the use and disclosure of your protected health information;
- Your rights with respect to your protected health information;
- The Plan's duties with respect to your protected health information;
- Your right to file a complaint about the use of your protected health information; and
- Whom you may contact for additional information about the Plan's privacy practices.

The Plan will follow the terms of this notice, as it may be updated from time to time. The Plan reserves the right to change the terms of its privacy policies at any time and to make new provisions effective for all health information that the Plan maintains.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your written authorization for purposes of Treatment, Payment and Health Care Operations. Here are some examples of what this encompasses:

- Treatment includes providing, coordinating, or managing health care by a health care provider or doctor. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share health information about you with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.
- Health Care Operations include activities by the Plan such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and the claims and appeal process. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to review the effectiveness of wellness programs.

The Plan will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH THE CITY OF PHOENIX

The Plan may disclose your health information without your written authorization to certain employees of the City of Phoenix who have been identified as performing plan administration functions. These employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures.

In addition, the HIPAA rules allow information to be shared between the Plan and City of Phoenix, as follows:

- The Plan may disclose "summary health information" to City of Phoenix if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information has been removed.
- The Plan may disclose to City of Phoenix information as to whether an individual is participating in the Plan, or has enrolled or disenrolled in a health benefit option offered by the Plan.
- The Plan may disclose to City of Phoenix information about retirees that is necessary to enable City of Phoenix to receive payment of the retiree prescription drug subsidy from the Centers from Medicare and Medicaid Services.

In addition, you should know that City of Phoenix cannot and will not use health information obtained from the health plans for any employment-related actions. However, health information collected by City of Phoenix from sources other than the Plan, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other Allowable Uses or Disclosures of Your Health Information.

Generally, the Plan may disclose your protected health information to a friend or family member that you have identified as being involved in your health care or payment for that care. In the case of an emergency, information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). In addition, your health information may be disclosed without authorization to your legal representative. Your spouse may receive information if you do not restrict or object, and either parent of a minor child may receive information if you do not restrict or object.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

As required by law	Disclosures to federal, state or local agencies in accordance with applicable law.
Workers' compensation	Disclosures to workers' compensation or similar programs in accordance with federal, state or local laws.
To prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety; includes disclosures to assist law enforcement officials in identifying or apprehending an individual in certain circumstances.
Public health activities	Disclosures for public health reasons, including: (1) to a public health authority for the prevention or control of disease, injury or disability; (2) a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.
Victims of abuse, neglect, or domestic violence	Disclosures to report a suspected case of abuse, neglect, or domestic violence, as permitted or required by applicable law.

Judicial and administrative proceedings	Disclosures in response to an order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process.
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process for law enforcement purposes.
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.
Health oversight activities	Disclosures to comply with health care system oversight activities, such as audits, inspections, or investigations and activities related to health care provision or public benefits or services.
Specialized government functions	Disclosures to facilitate specified government functions related to the military and veterans, national security or intelligence activities; disclosures to correctional facilities about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made.

YOUR INDIVIDUAL RIGHTS

You have the following rights in connection with your health information that the Plan maintains. These rights are subject to certain limitations, described below. Remember, the City of Phoenix does not generally receive or maintain individually identifiable health information from the Plan. In most cases, you should direct your requests to your medical or dental plan service representative.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse. You have the right to request a restriction or limitation on the Plan's use or disclosure of your health information. For example, you have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care.

Because the Plan only uses your health information to administer the Plan, and to comply with the law, it may not be possible to agree to your request. Except as provided in the next paragraph, the Plan is not required to agree to your request for restriction. However, if the Plan agrees, the Plan will comply with the restriction unless the information is needed to provide emergency treatment to you.

Except as required by law, the Plan will comply with your restriction request where: (1) the disclosure is to the Plan for purposes of carrying out payment or health care operations (and not for treatment purposes), and (2) the protected health information pertains solely to a health care item or service for which the health care provider has been paid in full out-of-pocket.

Right to receive confidential communications of your health information. You have the right to request that the Plan communicate with you about your health information at an alternative address or by alternative means if you think that communication through normal processes could endanger you in some way. For example, you may request that the Plan only contact you at work and not at home.

Right to inspect and copy your health information. You have the right to inspect or obtain a copy of your health information contained in records that the Plan maintains for enrollment, payment, claims determination, or case or medical management activities, or that the Plan uses to make enrollment, coverage or payment decisions. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

Right to amend your health information that is inaccurate or incomplete. With certain exceptions, you have a right to request that the Plan amend your health information if you believe that the information the Plan has about you is incomplete or incorrect. You must include a statement to support the requested amendment. The Plan will notify you of its decision to grant or deny your request.

Right to receive an accounting of disclosures. You have the right to a list of certain disclosures of your health information. The accounting will not include: (1) disclosures made for purposes of Treatment, Payment or Health Care Operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosure for national security purpose; and (6) disclosures incident to other permissible disclosures.

You may receive information about disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules became effective). You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to be notified of a breach. You have the right to be notified in the event that the Plan or a Business Associate discovers a breach of unsecured protected health information.

HOW TO EXERCISE YOUR RIGHTS IN THIS NOTICE

To exercise your rights listed in this notice, you should contact the City of Phoenix HIPAA Privacy Office at (602) 262-4777 or **benefits.questions@phoenix.gov.**

ADDITIONAL INFORMATION

If you have questions regarding this notice or the subjects addressed in it, you may contact the Benefits Office at (602) 262-4777.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a written complaint with the HIPAA Privacy Officer in the Benefits Office at 135 N. Second Avenue, Phoenix, AZ 85003.

You may also file a complaint with the regional Office for Civil Rights of the United States Department of Health and Human Services. Information on how to file a complaint is available on the Department of Health and Human Services website at **www.hhs.gov/ocr/hipaa**. You will not be retaliated against for filing a complaint.

NOTICE REGARDING WELLNESS PROGRAM

Fit4Phoenix is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to visit your primary care physician.

You are not required to complete the HRA or to visit your primary care physician. However, employees who choose to participate in the wellness program will receive an incentive of $40 or $60 per month for completing the HRA and completing a PCP visit. If the employee or covered spouse (or qualified domestic partner) do this, the incentive is $40. If the employee and covered spouse (or qualified domestic partner) do this, the incentive is $60. Although you are not required to complete the HRA or complete a primary care physician visit, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting **Kathy Bird, Wellness Coordinator, at 602-262-4777**.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program such as onsite preventive care, health coaching, webinars or classes. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and City of Phoenix may use aggregate information it collects to design a program based on identified health risks in the workplace, Fit4Phoenix will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact **Leslie Dewar, Deputy Director of Human Resources, at 602-262-6708**.

Contacts

<table>
<tr><td rowspan="2">City of Phoenix Benefits Office</td><td colspan="2">Benefits Office: (602) 262-4777</td></tr>
<tr><td colspan="2">Benefits.Questions@phoenix.gov</td></tr>
<tr><td rowspan="3">Banner|Aetna</td><td colspan="2">www.aetna.com/cityofphoenix</td></tr>
<tr><td colspan="2">24-Hour Health Information Line: (888) 747-7990</td></tr>
<tr><td colspan="2">Devon Moore
Onsite Representative
(602) 495-5724
devon.moore@phoenix.gov</td></tr>
<tr><td rowspan="3">Blue Cross Blue Shield of Arizona</td><td colspan="2">azblue.com
Registration questions and password reset: (602) 864-4844</td></tr>
<tr><td colspan="2">24-Hour Nurse On-call: (866) 422-2729</td></tr>
<tr><td>Sylvia Macias
Onsite Representative
(602) 534-5165
sylvia.macias@phoenix.gov</td><td>Member Services
(602) 864-4857</td></tr>
<tr><td>EnvisionRx
Pharmacy Benefits</td><td colspan="2">phxrx.envisionrx.com
Preview code: PHXRX. No registration necessary.
(833) 803-4402 (24-hour assistance)</td></tr>
</table>

Cigna Dental Benefits	mycigna.com	
	(800) 244-6224	
	Registration questions and password reset: (800) 853-2713	
	Cigna Dental Representative: linda.sawyer@cigna.com	
Avesis Vision Buy-Up Plan	avesis.com	
	(800) 828-9341, 7:00 a.m. to 8:00 p.m. EST	
ASIFlex Flexrap and COBRA	asiflex.com	
	asiflex.com/debitcards	my.asiflex.com
	Member Services: (800) 659-3035, Flexrap	
	Member Services: (877) 388-8331, COBRA	

City of Phoenix

This guide highlights the main features of the City of Phoenix Employee Benefits Program. It does not include all plan rules, details, limitations, and exclusions. Please keep in mind that summary plan descriptions, coverage certificates, policies, contracts, and similar documents prevail when questions of coverage arise. City of Phoenix reserves the right to change or discontinue its employee benefits plans at any time.